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ABSTRACT

The Phoenix, Arizona Early Head Start program is a family-centered program providing early, continuous, intensive, and comprehensive child development and family support services for low-income pregnant women and families with children ages birth to three. Analyses were conducted of program and participant data and program processes from Year 3, the second full year of implementation. The program components evaluated were: (1) child development, promoted through weekly home visits, site-based socialization activities, and weekly play groups; (2) family development services, provided by family support specialists to develop effective, supportive relationships, especially with fathers; (3) staff development, incorporating a multi-disciplinary approach reinforced by a relationship-based supervision model; and (4) community building and collaboration, including connections with Phoenix's program for young fathers and other family-focused initiatives. Evaluation findings suggest that the program is on the right track. Among the program's successes are the launch of all planned child development activities, increased services by and access to the child development/disabilities specialists, and progress made through the male involvement component. The program continues to face challenges, including increasing staff skills in child development and parent-child relationships, helping young parents adjust to dealing with toddlers, reducing disruptive effects of staff turnover, and making the program and participants visible and vital to other family-centered community endeavors and to policy makers. Recommendations for future operations were derived from the evaluation findings. (Contains 49 references.) (KB)

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On Track with Phoenix Early Head Start

1997-98 Evaluation Report

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On Track with Phoenix Early Head Start

1997-98 Evaluation Report

by
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with assistance from
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Submitted to:
Southwest Human Development

March 1999

Phoenix Early Head Start is funded under a grant to Southwest Human Development, Inc. from the Administration for Children, Youth, and Families, U.S. Department of Health and Human Services. This research was conducted by Morrison Institute under a contract with Southwest Human Development, Inc., Phoenix, Arizona.

Phoenix Early Head Start

Executive Summary

The 1997-98 project year concluded the second full year of program implementation for Phoenix Early Head Start, one of 68 original programs funded nationwide in 1995 (nearly 300 as of May 1998) to provide services for low-income pregnant women and families with children ages birth to three. Early Head Start is a family-centered program that is designed to offer early, continuous, intensive, and comprehensive child development and family support services for vulnerable families and their very young children.

The Phoenix Early Head Start (EHS) grantee is Southwest Human Development (SWHD), a non-profit human services organization providing comprehensive services to young children and families who are at-risk or have special needs. Southwest Human Development contracted with the Morrison Institute for Public Policy, School of Public Affairs, Arizona State University, to conduct a formative, continuous improvement program evaluation to assist Phoenix Early Head Start in refining program practices on an ongoing basis.

A detailed report of the program structure and planning phase during Year One of the project can be found in *Phoenix Early Head Start: 1995-96 Evaluation Report* (Sandler & Kleinsçhmidt, 1996). For research findings and analysis from Year Two—the first full year of program implementation—readers are directed to *On Track with Phoenix Early Head Start: 1996-97 Evaluation Report* (Sandler & Heffernon, February 1998). The current report documents and analyzes program and participant data and program processes from Year Three, the second full year of implementation of the Phoenix Early Head Start program.

Early Head Start Program Components

Phoenix Early Head Start recruits low-income teenagers 13 to 19 years old living primarily in central/south Phoenix who are pregnant with their first child or have an infant less than six months of age. The program has two sites: Hamilton Elementary School in west Phoenix, and the Southwest Human Development Good Fit Center in central Phoenix. Services to families are provided through three main program components: weekly home visits, site-based group activities, and "brokered" services linking families with high-quality community resources. Male involvement is a major program focus and involves concentrated outreach efforts to engage young fathers with their children. Parents also develop leadership and decision-making skills through participation in EHS parent policy committees as well as the more comprehensive Head Start Parent Policy Council.

Phoenix Early Head Start is designed to serve 120 families, with a primary staff of 12 family support specialists supported by two site supervisors and a resource staff that includes a family services manager, a male involvement specialist, two registered nurses, two half-time child development/disabilities specialists, a clinical psychologist, and mental health specialists. Program activities are also supported through the services of a van driver and part-time bus driver. Program components are intended to address the four original national Early Head Start cornerstones—child development, family development, staff development, and community building.

Child development is promoted through weekly home visits by the family support specialists, monthly site-based socialization activities centered around child development-related themes, and weekly play groups to encourage positive parent-child interactions. Additional support is provided by the child development/disabilities specialists who facilitate play groups, consult with families and staff on child development issues, and coordinate services for children with developmental delays or disabilities. Program nurses also assess the developmental and physical status of each child during periodic home visits, and provide consultation to EHS families and program staff.

Family development services are primarily provided by family support specialists who work with small caseloads of families in order to develop effective, supportive relationships with them. Family support specialists use videotapes made during home visits to help parents review and discuss their interactions with their children, and they work with parents on improving health care practices, family planning, education, and employment. Other family services are provided by the male involvement specialist who engages hard-to-reach fathers in the program, coordinates special events for fathers, and provides information and referral services in the areas of immigration, housing, and jobs. A full-time family services manager oversees all site-based activities, coordinates child care and transportation services, facilitates parent policy committee meetings, and links with community resources for volunteers and education activities. Program nurses conduct classes for EHS teens on childbirth, CPR/First Aid, and child care certification, and they also consult on adolescent health and development. Mental health specialists provide assessments, direct services, referrals, coordination of service delivery, and support groups in which parents can discuss commonly-shared issues and concerns. Family development is also enhanced through family-centered socialization activities and special events, and through leadership opportunities available through EHS parent committees and the Head Start Parent Policy Council.

Staff development occurs through a multi-disciplinary training approach that is reinforced by a relationship-based model of supervision. Training is provided both by outside trainers and by EHS resource staff (*e.g.*, the psychologist, nurses, and male involvement specialist), who offer sessions covering a wide range of subjects aligned with the desired program outcomes for children and families. Staff also have opportunities to attend national workshops and conferences. In addition, they participate in agency-wide SWHD training sessions that relate to their work with children and families.

Community building and collaboration is intended to help provide comprehensive, integrated services to EHS families. While an original partnership plan between SWHD and the City of Phoenix Head Start was more narrowly focused during Year Three than initially planned, collaboration grew between EHS and the city's Step-Up program for young fathers, and new connections have been implemented with the city's Human Services Department and other family-focused initiatives and resources. Phoenix Early Head Start also focuses on program-level efforts to strengthen community support for families with young children, and on administrative-level efforts to increase community capacity for serving children and families and to move the larger "0-3" policy agenda forward. Program-specific efforts generate linkages such as partnering with an organization that provides classes in HIV/STD prevention. Administrative and management-level activities include work to broaden community support for young fathers, and a SWHD agency partnership to develop a statewide conception-to-age-three agenda and implementation model that will focus attention on the state's vulnerable young families.

Program Outcomes

Phoenix Early Head Start is engaged in Year Three of a continuous improvement program evaluation that has been structured around the four original cornerstones of the national Early Head Start initiative and aligned with 1998 revised Head Start Program Performance Standards. The evaluation is

designed to answer questions about program services, child development, family development, staff development, and community building, as well as policy outcomes of local interest. A process evaluation during Year One examined program development and start-up, while a formative evaluation, begun in Year Two and extending through Year Five, will examine the effectiveness of program components, identify successes and challenges in achieving program objectives, and provide program managers with continuing feedback.

Children and Families

Issues of child and family development were the topics addressed most frequently during EHS home visits, with play groups and socialization activities also focusing on these areas. Most indicators support the conclusion that this strategy has had a positive effect. There were several small but significant gains in these areas which, in the aggregate, suggest promising trends. Parent knowledge of raising a baby has increased; most children appear to be living in nurturing home environments; parents report more interactions with their children; and children show generally positive relationships with their parents. The transition of children from infant to toddler in the past year, however, may be causing parents some difficulties. While parents have more knowledge of raising a baby, some have inappropriate expectations for toddlers; and while parents report more interactions with their children, the tone of these interactions may be more negative than previously.

Parent mental health appears stable despite high numbers of stressful events in their lives and some difficulties adjusting to toddlers. Indicators of parenting stress, coping skills, and sense of control have stayed relatively positive over time. One possible explanation for this stability is that the EHS program has been serving as a "protective factor," providing parents with support when they face emerging problems with their children. Parent mental health also appears to be positively correlated with the quality of parent-child relationships, and with knowledge of raising a baby: more frequent use of positive coping strategies by parents is related to higher reports of parent-child activities and also to reports of a more nurturing home environment; lower parental stress is related to reports of a more nurturing home environment and also to observations of more positive interactions with children; and more knowledge of raising a baby is related to lower parental stress and also to more frequent use of positive coping strategies.

The program focus on health, safety, and educational and economic self sufficiency has also produced some positive results. Most parents for whom data were available had received medical services in the previous six months, and more than half had practiced preventive health care and used some form of family planning. Also, more than half had attended an educational or job training program in the previous six months, more than a third had worked a full-time job, and some had transitioned from job training programs into full-time jobs. Child health and home safety issues, however, continue to raise some concerns. While most parents have maintained appropriate health care practices, some have not kept up with well-baby/well-child checkups or kept their children's immunizations current, and a large percentage of families for whom information was available were reportedly not providing a safe home environment, particularly in areas such as covering unused electrical outlets and knowing who to call in case of poisoning.

Staff Development

The majority of staff training efforts in 1997-98 targeted child development and parent-child relationships, with the result that family support specialists paid more attention to these priority issues during home visits. Assessment of staff's ability to apply their knowledge and skills in child development/parent-child relationships with families, however, highlighted wide ranges of ability and pointed out the need for more systematic concentration on these topics in the future. Following up on these results, program managers have made a decision to intensify training on child development and parent-child relationships during the upcoming year, and also to implement a child development curriculum that will assist family support specialists as they work with families.

In terms of their work with teen parents, family support specialists continue to show success. A trend in parent responses illustrates this point: the longer parents are in the program, the more positively they rate their relationships with family support specialists. By building strong relationships with parents, however, family support specialists can encounter difficulty in setting "professional boundaries." Experience suggests that this topic will require ongoing staff training, discussion, and clarification throughout the life of the program.

Community Building

Phoenix Early Head Start appears to be making appreciable progress toward building community capacity to assist young families. New linkages have been developed to connect participants with needs such as personal health care, and some earlier linkages have broadened into more collaborative relationships for coordinating and expanding community resources. Among these expanded relationships: connections with the City of Phoenix Step-Up program and other young father programs have grown into a broad-based community coalition that is increasing resources and pursuing new funding to support its agenda; EHS's relationship with the Village charter school evolved into a larger SWHD agency collaboration with a commitment of both fiscal and human resources; an initial linkage with the state's Developmental Disabilities Division has led to formation of a joint team to help coordinate state services for EHS children with disabilities, and may lead to joint staff training as well as a new support group for teen parents who have children with disabilities, available to any family in this situation.

The program has also begun to connect with some activities taking place in the City of Phoenix Enterprise Community (EC), within which EHS is located. These connections include collaboration on the young father initiative, as well as a beginning linkage with a program that connects EC residents with local jobs. In addition, EHS benefits from its synergistic relationship with its parent agency, SWHD, which is a provider of things such as infant mental health services, and is currently in the process of developing a high quality child care facility in central Phoenix. The EHS program also benefits from SWHD's active involvement in many projects and collaborations, one of the most promising of which is the agency's recent involvement in the design of a statewide system to support families and their very young children.

Some EHS relationships, however, have moved toward less engagement. An existing partnership with City of Phoenix Head Start, which was expected to be a full collaboration that included "big picture" program advisement, has focused most recently on administrative-level discussions of specific issues and policies. Nevertheless, some joint planning is expected to occur in the next few years over how best to serve Phoenix's 0-3 population.

Summary

At the conclusion of the 1997-98 project year, Phoenix Early Head Start can best be characterized as a fully evolved program that is on the right track. Among the program's successes are the launch of all planned child development activities, increased services by and access to the child development/disabilities specialists, and progress made through the male involvement component—not only in cultivating a network of resources for young fathers, but also in contributing to community leadership and development of young father initiatives. Staff have also maintained their previous success in working with teen parents and fostering healthier parent-child relationships.

The program continues to face challenges as it evolves. These include the challenge of continually increasing staff skills in the areas of child development and parent-child relationships; the challenge of helping young parents adjust to dealing with a toddler in their family; the challenge of reducing the disruptive effects of staff turnover; and the challenge of making the program and its participants visible and vital to other family-centered community endeavors and to policy makers.

Recommendations

The following recommendations are offered based on evaluation data gathered during the 1997-98 program year.

- Implement a focused, cohesive training agenda to provide EHS staff with sustained, comprehensive opportunities to improve their child development skills and knowledge.
- Deal proactively with issues involving children's transition from infant to toddler.
- Institute a standardized "EHS new employee orientation" to clarify program values, goals, guidelines, and procedures.
- Develop and implement a strategy to increase awareness of EHS among service providers and policy makers.

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Acknowledgments

"Continuous program improvement evaluation" has a nice ring to it. But successful partnering on such endeavors isn't easy. What has made this evaluation easier is that Phoenix Early Head Start staff and managers have been great collaborators in "doing" their part—and for that, we thank them. Our sincere appreciation to all the family support specialists who added the role of data collector to their many other tasks. And thanks also to Gloria Tufo and Kevin von Brubaker for their diligence, persistence, and—most important—good humor in translating "program data" into a format appropriate for evaluation purposes.

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Introduction

Project Overview

The 1997-98 project year (October' 97-September '98) was the third year of a five-year research and demonstration grant for Phoenix Early Head Start (EHS), and concluded the second full year of program implementation. Phoenix Early Head Start is part of the first 68 programs nationwide that were funded in 1995 by the Administration for Children, Youth, and Families to provide services for low-income pregnant women and families with children ages birth to three. Additional programs funded in subsequent years have brought the total of Early Head Start programs operating nationwide to nearly 300 as of May 1998. Established as part of the 1994 Head Start Reauthorization, Early Head Start is a family-centered program to provide early, continuous, intensive, and comprehensive child development and family support services for vulnerable families and their very young children. The program's purpose is to enhance children's physical, social, emotional, and cognitive development, to enable parents to be better caregivers and teachers of their children, and to help parents meet their own goals, including economic self-sufficiency.

Building on a large body of research and practice extending more than three decades, Early Head Start centers on four cornerstones considered essential to high-quality comprehensive programs: child development, family development, community building, and staff development (Advisory Committee on Services for Families with Infants and Toddlers, 1994; Early Head Start National Resource Center, 1998). These cornerstones have been integrated into the revised Head Start Performance Standards that guide the services for all Early Head Start and Head Start programs. While earlier performance standards focused on services to preschool children, the revised standards, which became effective in January 1998, cover the provision of services for pregnant women and children from birth to five years old. The standards have been reorganized into three areas: Early childhood development and health services, family and community partnerships, and program design and management. While the performance standards define the scope of services that are to be offered through Early Head Start/Head Start programs, they leave the design of the services to local programs based on local community needs (*Federal Register*, November 5, 1996).

The Phoenix Early Head Start grantee is Southwest Human Development (SWHD), a non-profit human services organization providing comprehensive services to young children and families who are at-risk or have special needs. Southwest Human Development offers a wide range of programs and services including the agency's Good Fit Center, designed to provide infant mental health services and programs, Head Start preschool programs, and the Maricopa County Healthy Families Program.

To assist Phoenix Early Head Start in refining program practices on an ongoing basis, Southwest Human Development contracted with the Morrison Institute for Public Policy, School of Public Affairs, Arizona State University, to conduct a formative, continuous improvement program evaluation. This evaluation recognizes the importance of program context, incorporating the perceptions of key stakeholders and involving program administrators and staff as partners.

A detailed description and analysis of the program structure and program planning phase during the first project year can be found in *Phoenix Early Head Start: 1995-96 Evaluation Report* (Sandler & Kleinschmidt, 1996). Readers are also directed to *On Track with Phoenix Early Head Start: 1996-97 Evaluation Report* (Sandler & Heffernon, February 1998) for research findings and analysis from Year Two, the first full year of program implementation. The current report documents and analyzes

program and participant data and program processes from Year Three of the Phoenix Early Head Start program.

Research Context

Recent years have witnessed growing support for the idea that providing prevention and intervention services for very young children and their families is a good investment (Carnegie Task Force on Meeting the Needs of Young Children, 1994; Advisory Committee on Services for Families with Infants and Toddlers, 1994; Center for the Future of Children, 1995, 1997; Zigler & Styfco, 1996). Increasing evidence about infant brain development has also heightened public awareness regarding the importance of improving opportunities for development during these very early years (*Newsweek*, 1997).

A multidimensional program, Phoenix Early Head Start incorporates research and knowledge from several domains to address the needs of at-risk infants and toddlers and their teen parents. Grounded in research on infant and early childhood development, "two-generation" interventions, and home visiting, the EHS program reflects an ecological or transactional approach that suggests that developmental outcomes for young children result from interactions among a variety of individual, family, and community factors (Bronfenbrenner, 1979; Sameroff & Fiese, 1990). This perspective frames the problems affecting children in a broader context, and moves programs in the direction of multiple intervention strategies (Garbarino, 1990; Barnard & Morisset, 1995).

In analyzing interventions for very young children, Emde (1996) highlights the need for programs that foster early socio-emotional development, which is critical to building strengths that can serve as protective factors throughout childhood. Such early socio-emotional development, he suggests, "will buffer against disorders not only of this age period but also against disorders of later ages that involve school engagement, social relatedness, conduct, and mood" (p.11). This key element in the Early Head Start initiative is supported through the nurturance of strong child-caregiver relationships.

Research and practice also support the belief that impoverished families benefit from two-generation programs designed to address the needs of both parents and children. By helping parents meet basic needs, gain some control over their lives, and develop good parenting skills, these types of interventions are believed to help establish children and families on a positive life course (Layzer & St. Pierre, 1996; Zigler & Styfco, 1996; Schorr & Both, 1991). Scientific evidence also continues to accumulate linking home visiting programs for infants and their parents with positive outcomes such as reduced child abuse and juvenile crime prevention (Sherman, 1996), improved outcomes for pregnant women, improved quality of parental caregiving, improved home-rearing environments for children, improved childhood safety, and increased parent participation in the labor force (Kitzman, Olds, *et al.*, 1997; Olds, 1997).

The interconnectedness of children, families, and communities is one of the premises for a group of services generally identified as "family support," described by Kagan (1996) as programs that "seek to build on family strengths and to empower families, converting the focus from one in which 'clients' receive services to one in which families are 'partners' in designing and constructing services" (p. 157). The provision of comprehensive, flexible, and responsive services that deal with a child as an individual and as part of a family, and with the family as part of a community, has also been found to be a common characteristic of successful programs (Schorr, 1998; Schorr & Both, 1991; Schorr, 1988). A decade review of early interventions with disadvantaged and disabled children similarly identified a holistic approach to addressing the needs of vulnerable children and their families, concluding that "for children whose social and economic environments threaten their development, intervention should focus more directly on those environments themselves: job training for parents...parental support groups, and groups that empower parents rather than disenfranchise them" (Farran, 1990, p. 533).

Also relevant for EHS is the body of research about high risk youth. Low-income neighborhoods like those served through the program are characterized by conditions such as violence, drug

sales, and school failure—circumstances that are more likely to place young people at risk. The research on adolescent risk and resiliency (Dryfoos, 1998) has identified common characteristics of resilient youth that can help counter some of these conditions, including attachment to a caring adult, independence and competence, and high aspirations—all elements that factor into EHS's work with teen parents.

The research context for Phoenix Early Head Start is underscored through the cornerstones and revised Head Start Performance Standards that guide the program. Early childhood development performance standards focus on providing comprehensive child development services to children birth to five. Family and community partnership performance standards are designed to develop collaborative relationships among the program, families, and community-based organizations; to assist families in meeting their needs; and to help develop a community environment of shared responsibility for healthy child development. And program design and management performance standards, providing the anchor for quality services to children and families, are intended to ensure organizational structures that support a high-quality staff and program governance that actively involves and empowers parents in making program decisions (Development Associates, Inc., April 22, 1996).

Program Description

Phoenix Early Head Start recruits low-income teenagers 13 to 19 years old living primarily in central/south Phoenix who are pregnant with their first child or who have an infant less than six months of age. The program is offered through two sites: 1) Hamilton Elementary School in west Phoenix, and 2) the Southwest Human Development Good Fit Center in central Phoenix. Services to families are provided through three main program components: weekly home visits, site-based group activities, and "brokered" services linking families with high-quality community resources. Male involvement is also a major focus of the EHS program, with concentrated outreach efforts to engage young fathers with their children and to support that ongoing relationship. Parents are also afforded opportunities to develop leadership and decision-making skills through participation in EHS parent policy committees as well as the larger and more comprehensive Head Start Parent Policy Council.

Phoenix Early Head Start is designed to serve 120 families, with a primary staff of 12 family support specialists and two site supervisors. Program services are further supported by a resource staff that includes a full-time family services manager, male involvement specialist, two registered nurses, and two half-time child development/disabilities specialists. Mental health resource staff members include a clinical psychologist who supervises and coordinates mental health referrals; a clinician with a master's degree in psychology; and doctoral-level clinical psychology interns. A full-time van driver and part-time bus driver comprise the rest of the program's resource staff.

Early Head Start Program Components

Phoenix Early Head Start is designed to provide program participants with comprehensive early childhood development and family development services by facilitating positive parent-child relationships, improving infant-toddler developmental outcomes, helping ensure access to appropriate health care and child care services, fostering parent self-sufficiency, and actively engaging fathers with their children. Program components are intended to generate outcomes in the four domains that comprise the original national Early Head Start cornerstones—child development, family development, staff development, and community building.

Child development is promoted through weekly home visits by the family support specialists who assist parents in planning developmentally appropriate activities for their children. Healthy parent-child interactions are also supported through monthly site-based socialization activities, several of which are centered around child development-related themes. Parent-child play groups implemented during the past year offer additional child development support and encourage positive parent-child interaction.

Child development support is also provided by the EHS child development/disabilities specialists. The addition of a second staff person this year allowed each EHS program site the services of a half-time child development/disabilities specialist. These specialists consult with families and staff on child development issues, facilitate play groups for families at each program site, coordinate services for children with disabilities, and administer the Infant-Toddler Developmental Assessment (IDA). Children identified with developmental delays or disabilities are referred for further assessment as needed. The developmental and physical status of each child is also assessed during periodic home visits by the program nurses, who likewise provide consultation to EHS families and program staff as needed.

Family development includes an array of program services delivered primarily through the family support specialists, with additional support provided by the EHS resource staff. Each family support specialist works with a relatively small caseload of 10 families to enable them to develop effective, supportive relationships with the family and provide the necessary mix of intensive and comprehensive services. One of the key program strategies employed to help parents develop healthy relationships with their children is the ongoing use of videotaping. Tapes made during home visits provide a tool for parents and family support specialists to review and discuss the parent's interactions with their children. The family support specialists also work with parents on personal development issues including health care practices, family planning, education, and employment.

Family development in EHS is also fostered through the activities of the male involvement specialist who, through one-on-one relationships, tries to engage hard-to-reach fathers in the program and in the lives of their children. In addition to working intensively with a caseload of six hard-to-engage fathers at any one time, the male involvement specialist coordinates monthly "Dad's night out" activities and special events such as a Father's Day outing that took place this year. He also continues to provide information and referral services, particularly in the areas of immigration, housing, and jobs. An expansion of job responsibilities moved this position in a somewhat different direction this year, precipitated by the departure of the male program manager. The male involvement specialist has become increasingly involved in local community collaboration activities and also facilitates male involvement workshops, both in-state and out-of-state.

The family development component of EHS was enhanced this year with the addition of a full-time family services manager who coordinates, plans, and oversees all site-based activities. Overall responsibilities include coordinating child care and transportation services, facilitating parent policy committee meetings, and linking with community resources to enlist volunteers and organize other socialization and education activities.

Additional services for EHS families are provided by the program's nurses and mental health specialists. The nurses conduct childbirth classes for EHS teens, as well as classes for CPR/First Aid training and child care certification. They also offer ongoing consultation on adolescent health and development. The mental health specialists provide assessments, direct services, and community referrals and coordination of service delivery to Phoenix Early Head Start families. Support groups facilitated by the mental health specialists continue to offer a forum in which parents can discuss commonly-shared issues and concerns. Groups are offered for both mothers and fathers. The mom's support groups have expanded this year to include separate groups for Spanish-speaking and English-speaking mothers. Groups meet weekly and are currently structured as "open-entry, open-exit."

Other activities that facilitate family development include the monthly site-based socialization activities and special events such as a weekend family picnic held this year at a local park. The addition of a 30-passenger bus and half-time bus driver this year further assists parents with the transportation needs associated with these types of activities.

Family development is also enhanced through the leadership and decision-making opportunities

available to parents through their participation in EHS parent committees and the more comprehensive Head Start Parent Policy Council. Participation in these groups solidified during the last year. A total of 12 parents (six from each site) serve on EHS parent policy committees and eight parents (four from each site) are representatives to the Head Start Parent Policy Council. Several EHS Council members were given the opportunity to attend national, regional, and state conferences over the course of the year.

Staff development occurs through a multi-disciplinary approach to staff training and is reinforced through a relationship-based model of supervision. Staff training is aligned with the desired program outcomes for children and families and covers a wide range of subjects, including areas specific to the EHS program intervention as well as to the larger SWHD agency. Training is provided both by outside trainers and Phoenix Early Head Start resource staff (*i.e.*, mental health coordinator, nurses, and the male involvement specialist). Training topics during these sessions include areas such as discipline, CPR and first aid, health and safety, and early childhood illnesses. As part of the EHS male involvement component, family support specialists receive training on the program's philosophy of male involvement, strategies for involving men in the program, and fathers' impact on their child's development. Staff also have opportunities to attend national workshops and conferences.

Community building and collaboration to help provide comprehensive, integrated services to EHS families is an integral part of the program's design. Phoenix Early Head Start was originally conceived as a partnership between SWHD and the City of Phoenix (primarily with the city's Head Start program and the Step-Up program for young fathers). Since EHS families are recruited from an area served by both entities, this approach made sense for a program dedicated to creating a coherent system of services for its participants. The partnership was originally operationalized through an EHS technical team that included SWHD/EHS managers and staff along with City of Phoenix Head Start and Step-Up representatives. The group's charge was to help with big-picture problem-solving and guidance. After experiencing declining attendance and increasing uncertainty about the team's purpose over the course of the first two program years, the EHS technical team was not operational during Year Three. Active collaboration has continued, however, between EHS and the Step-Up program, and additional connections have been implemented with the city's Human Services Department. In addition to its relationship with the City of Phoenix, EHS links with a variety of other family-focused initiatives and resources.

Phoenix Early Head Start focuses on strengthening community support for families with young children at both a programmatic and administrative level. Program-specific linkages that directly assist EHS families continue to be initiated and supported, such as a partnership with an organization providing participants with classes in HIV/STD prevention. At the same time, a variety of broader-based administrative and management level activities are intended to help increase community capacity for serving vulnerable children and families and to move the larger community policy agenda forward. One particular area of attention during the past year has been that of helping broaden community focus on young fathers. A SWHD agency partnership to develop a statewide conception-to-age-three agenda and implementation model was also initiated this year. It is intended to provide focus and attention on the state's vulnerable young families.

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Methods

Evaluation Design

Phoenix Early Head Start is engaged in a continuous improvement program evaluation structured around the four original cornerstones of the national Early Head Start initiative and aligned with the 1998 revised Head Start Program Performance Standards. The evaluation is designed to answer questions about program services, child development, family development, staff development, and community building. Policy outcomes of local interest are also considered.

A process evaluation during Year One examined program development and start-up. Formative evaluation, begun in Year Two and extending through Year Five will examine the effectiveness of program components, identify successes and challenges in achieving program objectives for children, families, staff, and the community, and it will provide program managers with continuing feedback. The complete evaluation design is presented in Appendix A. Program outcomes in the domains described below form the focus for the evaluation.

Infant-Toddler outcomes address four areas: infant-toddler development, developmental delays or disabilities, healthy parent-child relationships, and infant-toddler health.

Family outcomes address five areas: adult-child relationships, parent mental health, personal health care practices, educational self-sufficiency, and economic self-sufficiency.

Staff outcomes address four areas: supportive alliances with families, strategies for adolescent parents, child development and parent-child relationships, and "core" knowledge.

Community and policy outcomes address collaborative efforts and the program's influence on public policy.

Instruments and Data Collection

Both qualitative and quantitative data are being gathered, with a large part of the data collection being conducted by EHS program staff. Some child and family assessment data are being used both programmatically and evaluatively. For example, two infant-toddler instruments selected by EHS administrators to assess developmental status for program purposes will also be used to follow child progress over time. An instrument for program nurses to monitor the home environment will also be incorporated into the evaluation data. And parent assessment batteries developed for the evaluation will also become part of the program files, thereby enabling family support specialists to use the information in their work with individual families.

Parent assessment batteries incorporate established instruments, items adapted from the national Early Head Start evaluation, and locally developed tools. The local *Parent-Child Observation Checklist* provides family support specialists with uniform criterion for continually assessing the quality of parent-child interactions as they observe them. This instrument is first administered during the six-month assessment, and then again as part of each subsequent parent assessment battery.

Parent and staff surveys, and interview and focus group protocols address questions about program implementation. Interview protocols to elicit more specific and in-depth information are being utilized with 12 families and their family support specialists as part of a case study analysis that is following families throughout their involvement in the EHS program.

Two new instruments designed to help assess the effectiveness of staff training were implemented this year. The first asks family support specialists

to analyze videotapes and respond to several questions. The second is a staff knowledge assessment.

Data collection occasions for EHS are based on three timetables: 1) Parent assessments are linked to a family's time in the program; 2) child assessments are administered based on the child's age; and 3) interviews, surveys, focus groups, and staff assessments are completed annually. This document, therefore, reports on data sets that vary in both "size" and "cycle": some provide two years of information for analysis, while others represent baseline measurements.

Following are descriptions of the types of instruments and the data collection procedures for each. A brief summary of each evaluation instrument is presented in Appendix B.

Child Assessments

Child development is appraised using the *Infant-Toddler Developmental Assessment (IDA)* and the *Denver II*. These instruments are also used programmatically to identify initial developmental delays or concerns, and to monitor an individual child's developmental progress.

The *IDA* is administered by the child development/disabilities specialists when children are 12 months, 24 months, and 36 months old. The *Denver II* is administered by EHS nurses when children are 45 days old, six months, 18 months, and 30 months.

The quality of the home environment is assessed for program purposes by the EHS nurses using the *Infant/Toddler Home Inventory (HOME)*. Administration of the *HOME* occurs for the first time when the child is 45 days old or less, or upon program entry. Subsequent administration of the *HOME* occurs at 12-18 month intervals. In the future, the program plan is to administer the inventory on three assessment occasions: at 0-45 days or upon program entry, at 18 months old, and at 30 months old.

Qualitative information from these assessments is entered into the database maintained by the EHS program and used by staff in working with their families. *IDA* information is also converted to quantitative summary data enabling evaluators to track overall child outcomes. Furthermore, evaluators are reviewing *Denver II* screening data and the *HOME* scores to help describe children's developmental status and the quality of the home environment over time.

The home environment is also assessed at six-month program intervals using a subset of questions from the Infant/Toddler Home Inventory. Family support specialists complete this *Home Assessment* as part of the parent assessment battery, described in the section that follows.

Parent Assessments

Parent assessment batteries are administered according to a family's length of time in the program. Family support specialists administer the enrollment assessment to collect baseline data within three weeks of the start of program services. This is followed by subsequent participant assessments at six month intervals throughout the program. Evaluators and program administrators agreed that this would be the most effective way to address the burden of work for family support specialists who are responsible for assessing each of their families.

Since parent assessment occasions are linked to time in the program rather than to a child's age, each assessment battery must incorporate instruments that are developmentally appropriate for the full spectrum of possible ages of children at that time. Therefore, the array of individual instruments included in each assessment battery—and the specific instruments that each parent completes—is determined, respectively, by the age range anticipated for the total group of children, and the actual age of each child when the assessment is administered. Instruments address desired program outcomes in such areas as: knowledge of infant/toddler development; knowledge and practice of home safety; parent-child relationships and interaction; and parent mental health.

Family support specialists administer the parent assessment batteries during regularly-scheduled home visits. They have a one-month "window" following the six-month target date within which to complete the assessment. Spanish translations of assessment batteries are used with approximately 20 percent of program families.

Surveys

Toward the end of the 1997-98 program year, Phoenix Early Head Start parents and staff completed the second cycle of annual surveys to provide information about program implementation. Parents surveys were conducted in July and August 1998, with initial distributions of surveys taking place during a monthly activity at each program site. Attending parents completed the survey at that time, mothers and fathers each answering their own survey. For Spanish-speaking parents, a Spanish-language version of the survey was available and a translator helped the evaluator explain the process. Parents who were not present at the initial session received their surveys from family support specialists during their next home visit. In families where both parents are involved in the program, individual surveys were left for each parent and parents were instructed to complete the survey *after* the family support specialist left. They were provided with a stamped, self-addressed envelope to mail the completed survey directly to the evaluator.

Staff surveys were conducted with family support specialists at a meeting with the evaluator in July 1998. Site supervisors were also asked to complete a brief questionnaire about each of the family support specialists they supervise, as well as a questionnaire about their staff as a whole. Supervisors mailed their completed questionnaires to the evaluator in August 1998.

Family support specialists were also asked to complete a "staff knowledge assessment" for the first time this year. This assessment was administered in early October 1998. Questions were composed by some of the individuals who conducted staff training sessions throughout the year.

Videotape Analysis

A staff videotape analysis instrument was added this year as a way to gauge how staff implement what they have learned with families. Family support specialists watched videotapes of mothers and their children at two different stages of child development and, based on what they saw, they were asked to make several observations and assessments related to child development and parent-child interactions.

Interviews and Observations

Qualitative data about program implementation were gathered through focus groups, interviews, and observations of program meetings and activities. Three focus groups were conducted during August 1998, one with family support specialists and two with parents. Groups were guided by interview protocols developed by the evaluators. Sessions lasted between one and two hours, and were audiotaped and transcribed. The evaluator facilitated the family support specialist focus group and the group for English-speaking parents. The parent focus group for bilingual and monolingual Spanish-speakers was facilitated by a consultant working with the EHS evaluation team who has some familiarity with the program. The evaluator reviewed the interview protocol with the consultant prior to the focus group, and also attended the session. For their participation, parents received a $20 gift certificate for use at a local store.

Personal interviews were conducted with EHS/SWHD management and administrative staff, site supervisors, and the male involvement specialist. As before, interview protocols continued to focus on strengths and challenges in implementing program components, community linkages and collaboration, and staff development. Interviewees were also asked to reflect on any challenges the program might face in the remaining two years.

The evaluator attended more than 70 hours of key EHS meetings and program activities throughout the 1997-98 program year, primarily in the role of participant/observer. This included selected all-staff meetings, site-based team meetings, site-

based socialization activities, and parent policy committee meetings. Meeting observations were documented and analyzed, and when available, meeting minutes were reviewed. In addition, periodic evaluation management meetings and EHS evaluation subgroup meetings focused on emerging issues related to continuous program improvement.

Case Studies/"Family Stories"

Case studies are being conducted with a subset of EHS families to provide background and contextual information about their experiences with the program. Parents involved in the case study each agreed to be followed throughout their participation in the program so that their "stories" could be updated as they unfolded from one year to the next. A representative random sample of 12 families—reflective of program participants' age and ethnicity—were selected and initially interviewed last year. All 12 families were still active participants in the program as of August 1998, and they compose the 1997-98 case study cohort. Four of the families are Spanish-speaking. Case study methodology outlined by Yin (1994) and standards for case study research from the U.S. General Accounting Office (1990) guided evaluators in developing the case study outline and interview protocols for parents and family support specialists. Interview protocols, modified this year to reflect families' progression in the program, were based on the earlier version developed by evaluators and reviewed by program administrators and staff. Components of the case study/family story include an annual interview with participating families, annual interviews with their family support specialists, and a review of their participation and assessment data. Families receive a $20 gift certificate for use at local stores upon completion of their interview.

Interviews for 1998 were conducted between August 10 and August 17. All the families were interviewed by the same evaluator, but the four interviews with Spanish-speaking families included a translator present. Interviews generally lasted less than one hour, and were audiotaped for later review.

Participants

The participants included in this study are 146 teen parents who were enrolled in EHS prior to September 30, 1998 and identified as primary caregivers (144 mothers; 2 fathers).[1] Evaluation data are based on this group of participants and their first-born children (*i.e.*, the "focus child"). The involvement of fathers is considered a key EHS program component, therefore "engagement" of fathers with their children and participation in program activities is encouraged from the start. When appropriate, program participation data for fathers (*e.g.*, site-based activities, father-child activities) are included and noted in this report.

While the EHS program is designed to serve 120 families, the number of participants-enrolled at any one time varies. Participants leave the program for a variety of reasons (these are discussed in the section that follows), and replacement of program families is ongoing. As a result of this cycling in and out of families, the size of the data sets available for analysis also varies, since participants complete assessments based on their length of time in the program. In addition, an important caveat to the evaluation data is that analyses are based on all participants for whom data were available, regardless of whether or not some of these participants subsequently disenrolled from the program.

Demographic and background information was collected from participants at program enrollment. Since many EHS participants live at home with *their* parent(s) and siblings, the information that follows for participants' families refers to this extended family unit when appropriate.

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[1] A total of 164 participants have actually been enrolled in EHS since the program's inception. The 146 study participants are those people for whom both participation and assessment data are available. Demographic and enrollment data are reported for this group. The number of participants included in individual trend analyses varies, however, depending on the number of people for whom "matched" data are available for any two particular assessment points.

Phoenix Early Head Start parents were between 13 and 19 years old at the time of their enrollment in the program, with an average age of 17.1 years. At time of enrollment, 91 percent of EHS participants were single; 9 percent were married. Nearly 62 percent of the parents described themselves as Mexican/Chicano, and almost 22 percent described themselves as black, while the remainder were 8.9 percent white, 5.5 percent biracial/multiracial, and 2.1 percent Vietnamese, Central American, or American Indian. In 47.3 percent of the homes English was the primary language spoken, while in 30.8 percent of the homes Spanish was the primary language. Another 21.2 percent of participants said both languages were spoken in the home, while less than one percent indicated some "other" primary language (Figures 1-3).

The most common source of public assistance reported by parents was the WIC program (Women, Infants, and Children), with 64.4 percent of families enrolled. Parents also said that 58.2 percent of their families received medical financial assistance such as AHCCCS or Medicare. In addition, 28.8 percent of families reportedly received food stamps, 21.2 percent TANF (Temporary Assistance to Needy Families), and 16.4 percent received SSI (Supplemental Security Income) (Figure 4).

At program enrollment, EHS parents were asked to appraise their family circumstances by rating the adequacy of their resources to meet 21 basic needs such as housing, medical care and transportation. Overall, parents reported an average of three areas each for which their family resources were inadequate. The specific number of areas for which families reported inadequate resources ranges from 0 to 19. The five problems most frequently cited are listed in Table 1.

Figure 1

Parent Age at Enrollment

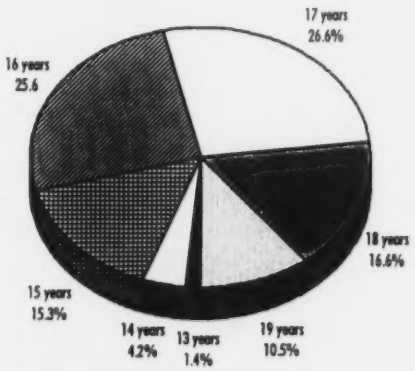


Figure 2

Parent Ethnicity

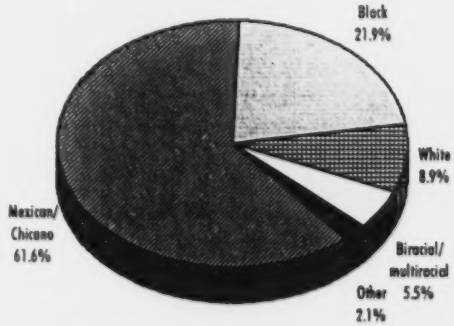


Figure 3

Language Spoken at Home

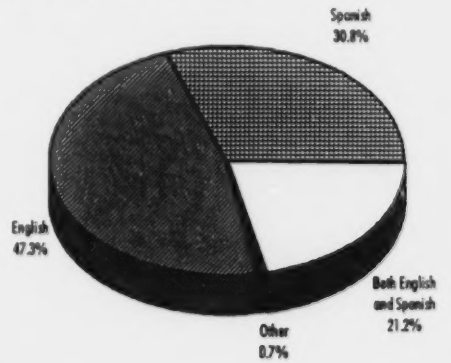
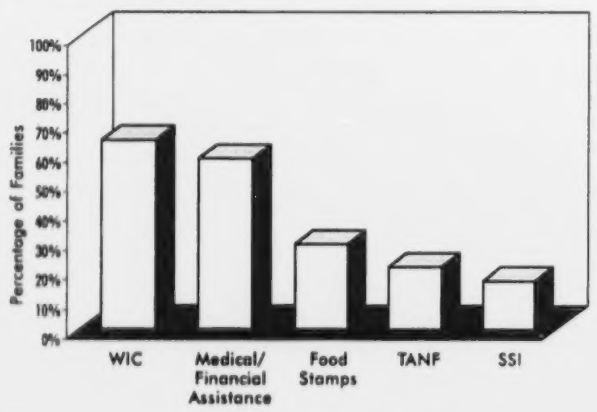


Figure 4

Public Assistance Snapshot: Family Status at Enrollment*



*Includes participants and the family members with whom they live (*e.g., their* parents)

The turnover of families during the first two years of EHS did not result in substantial changes in the demographic profile of program participants. For example, the distribution of parents' age and ethnic background at program enrollment was similar for both 1996-97 and 1997-98. Two fluctuations, however, were noted: the percentage of homes in which Spanish was the primary language decreased from 42 percent in 1996-97 to 31 percent the following year; at the same time, the percentage of homes in which both English and Spanish were spoken increased from 14 percent in 1996-97 to 21 percent in 1997-98.

Table 1

Percentage of Families with Inadequate Resources: Top Five Problems

Area of Need	% of Families
Job for self or spouse/partner	34.1%
Dental care for family	30.1%
Opportunities to participate in community groups	27.5%
Dependable transportation	23.6%
Medical care	19.8%

Participant Attrition

As mentioned in the previous section, EHS has experienced considerable participant turnover. Some 54 of the participants (37%) included in this study had disenrolled from the program by September 30, 1998 (*i.e.*, they left the program some time during the last two years). Participants disenrolled for a variety of reasons. Some families moved out of the program service area, while others stopped actively participating (*i.e.*, they continually missed home visits). In other cases, families had been successful in meeting their goals and felt they no longer needed, or had time for, program services.

During the past year the EHS staff drafted a program transition plan to help address participant attrition. When families move out of the service area, attempts will be made to link them with another Early Head Start or appropriate early intervention program. Efforts are also made to re-engage families whose program participation has dwindled. If a family continues to miss home visits, however, they will be disenrolled from the program based on guidelines established by the EHS Parent Policy Committee. For families who choose to leave the program because they are succeeding at meeting their goals and becoming self-sufficient, EHS staff will plan with them for transitioning out.

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Family Services and Outcomes

Parents are their children's primary caregivers and educators. Services for families in Phoenix Early Head Start are designed to support parents in these roles, assist them in meeting their families' immediate and long-term self-sufficiency needs, and help them along a path towards economic stability. Family services are primarily coordinated by family support specialists, who develop supportive alliances with families. The male involvement specialist, who helps engage young fathers in the program and in the lives of their children, also serves families, and additional services are provided by EHS resource staff.

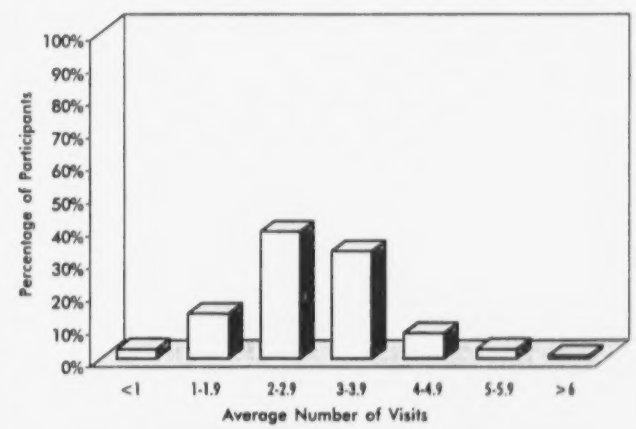
Family support services are delivered through home visits, site-based activities, parent-child play groups, parent support groups, and the parent committees and parent policy council. Implementation of several of the family support services is facilitated by the program's family services manager, who coordinates, plans, and monitors the specific details necessary to support these types of activities. Taken as a whole, these multiple program activities address the comprehensive goals and desired outcomes for participants in the program and their families, and thereby form the basis of the EHS intervention.

To assist families in identifying and meeting their goals, family support specialists help parents develop a "family partnership agreement" (FPA) in which they assess their individual strengths and needs. The FPA serves as a "road map" for helping families meet their identified goals. Family progress is discussed in multi-disciplinary team (MDT) reviews conducted at six-month intervals. The MDT process furnishes the opportunity for family support specialists, resource staff, and program supervisors to assess a family's status and provides the foundation for ongoing planning.

The fundamental program intervention strategy for supporting families is ongoing, frequent home visits. During the 1997-98 program year, EHS staff visited families an average of 2.9 times per month,[2] while the average number of visits per month to individual families ranged from less than one to 6.6 (Figure 5) . Because each family's needs and willingness to participate in services are different, however, the extent or "intensity" of services to each family varied.

Figure 5

Average Number of Visits Per Family Per Month: 1997-98



[2] This figure is based on participants who were enrolled in the program at the end of the 1997-98 program year (*i.e.*, on September 30, 1998). Participants who disenrolled from the program during the program year were excluded from this calculation, since these people often have been "missing in action" for several months prior to being disenrolled—during which time they would register *no* visits.

The intensity of service delivery also varied for different categories of services addressed during visits with EHS families. During the past year the greatest focus of these visits has been on child and family development, with 56 percent of the issues discussed falling within these two categories. Table 2 delineates the proportion of each visit devoted to major program service categories: child and family development, education and employment, medical issues, social services, child care, and emergency services.

Table 2

Percentage of Contacts* by Service Category per Visit

Service Category	% of Contacts Addressing These Issues
Child and family development	55.8%
Education and employment	17.1%
Medical	12.3%
Social services	8.4%
Child care	5.2%
Emergency	1.1%

*Percentage of time these issues were addressed
Note: Each service category includes several topics/issues. Therefore, each category can be addressed more than once during the same visit.

In addition to regular home visits, EHS parents are encouraged to participate in program activities with their peers, such as site-based socialization activities and parent support groups. These activities provide a source of social support as well as information on issues related to both parents and children. During the 1997-98 program year, EHS mothers attended an average of six socialization activities, with individual attendance ranging from 1 to 12 activities. An apparent "core" group consisting of 20 percent of these parents each attended eight or more socialization activities during the year. Overall, more than 70 percent of participants enrolled in the program during the past year attended at least one socialization activity.

Parent support groups continued to provide participants with both a forum for sharing their personal concerns, and a safe place in which to exchange ideas with their peers. Overall, more than a quarter of parents enrolled in EHS during the last year attended at least one parent support group session. Among those who participated in support groups, the average attendance was eight sessions, with individual attendance ranging from 1-29 sessions. Again, a core group of nearly 30 percent of parents appeared, each participating in nine or more support group sessions.

Through the efforts of the male involvement specialist and the family support specialists, EHS has been successful in engaging more fathers in the program and in the lives of their children during the past year, with 31 fathers receiving program services. On average, these fathers attended three male involvement activities, with an individual range from 1-9 activities. Nineteen (61 percent) participated in male involvement activities such as "Dad's Night Out" or events with the Step-Up program for young fathers. In addition, many fathers also participated in other integral EHS program activities: 20 participated in at least one home visit (individual frequencies ranging from 1 to 17 each), and half attended group socialization activities (individual frequencies ranging from 1 to 5 each). These have produced desired outcomes for some fathers. According to one father who spoke during a parent focus group: "I felt confused before. Thought I was the only one going through it. I met [the male involvement specialist]— he's great. People seem to go out of their way to help you."

The following subsections present parents' status and/or progress related to program outcomes in five primary domains: 1) adult-child relationships, 2) parent mental health, 3) personal health care practices, 4) educational self-sufficiency, and 5) economic self-sufficiency.

Adult-Child Relationships

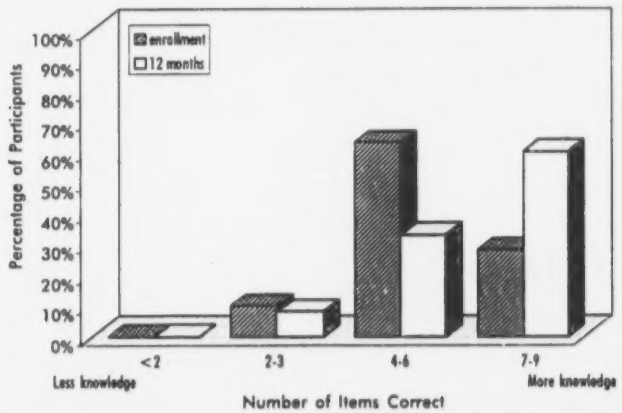
One of the primary purposes of the EHS program is to help parents understand their children's needs at different stages of their development and then respond to those needs in an appropriate way.

Program services, therefore, are intended to help parents form realistic expectations for their children's behavior and use effective parenting skills within the context of those expectations. Progress in developing positive adult-child relationships was tracked using instruments adapted from the national Early Head Start evaluation and through locally developed measures.

In order for parents to form realistic expectations for their children, they must first understand how children typically develop. Parent knowledge of infant development was assessed using a nine-item scale (*Raising a Baby*) that measures general understanding of infant norms and milestones, developmental processes, and caregiving strategies. Possible scores range from 0 to 9, with a higher score indicating more understanding of child development and positive parenting practices (Figure 6). Overall, EHS parents demonstrated a significant increase in their knowledge about raising a baby between the time they enrolled in the program and after 12 months of program participation. Mean scores for parents assessed at enrollment and 12 months show a statistically significant improvement, from a mean of 5.5 when they first enrolled to a mean of 6.4 after one year in the program.

Figure 6

Knowledge of Raising a Baby at Enrollment and After 12 Months of Program Participation



Looking at specific items, significant change occurred in parents' knowledge regarding realistic and developmentally appropriate expectations for children's behavior, particularly in the areas of sharing and cooperation and children's understanding of parental prohibitions. Positive trends also appeared regarding knowledge of individual differences in children's needs and rate of development (*i.e.*, parents know that not all babies are alike). But while parents showed an increased awareness of the importance of holding and cuddling babies, the majority did not seem to understand that some babies find typical cuddling uncomfortable (Table 3).

After 18 months in EHS, parents are asked to respond to a revised instrument for assessing their knowledge of child development (*Raising a Child*) that uses a 13-item scale modified to include questions about toddlers. Several items from the earlier (*Raising a Baby*) instrument are retained in the new measure, while a number of new items are added. Possible scores range from 0-13. Parents who had been enrolled in EHS for 18 months who completed this instrument had an average score of 9.6, with individual scores ranging from 4 to 13.

It is noteworthy that parents' knowledge of raising a baby "held" over time (*i.e.*, "program effects" did not disappear). This knowledge, however, did not generalize to parents having developmentally appropriate expectations for toddlers, as many parents appeared to make inappropriate attributions about toddlers' behavior and misbehavior. For example, more than 40 percent of parents said that "children will not do the right thing unless they must," and more than 60 percent believed that "children will be bad unless they are taught what is right."

Adult-child relationships were also examined through assessments of the home environment, which look at interactions between children and parents. Two different instruments were completed— one by family support specialists, the other by EHS nurses. The first appraisal of home environment is called *Home Assessment* and consists

Table 3

Knowledge of Raising a Baby: Item Analysis

Item	Percentage of Correct Answers	
	Enrollment	12 Months
1. All infants need the same amount of sleep	43%	55%
2. Taking care of a baby can leave the parent feeling tired, frustrated, or overwhelmed	83%	83%
3. A one-year old knows right from wrong	73%	70%
4. Some normal babies do not enjoy being cuddled	51%	40%
5. The more you comfort crying babies by holding & talking to them, the more you spoil them	65%	75%
6. A good way to train children not to hit is to hit them	90%	98%
7. Most infants are ready to be toilet trained by one year of age	55%	73%
8. Five-month olds understand what "no" means	70%	95%*
9. One-year olds often cooperate and share when they play together	25%	50%*

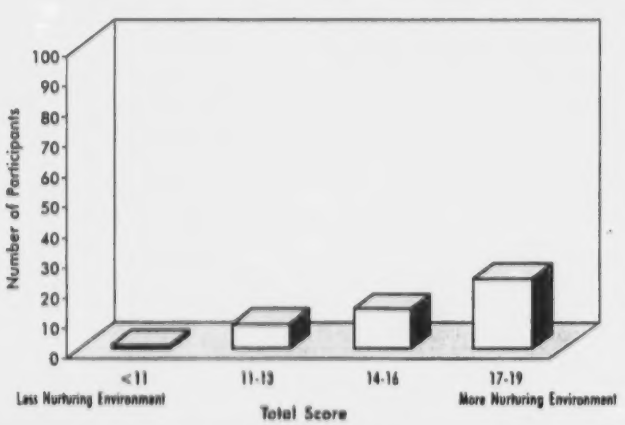
*Statistically significant change

of a subset of questions adapted from the Infant/Toddler Home Inventory. These questions are included in the assessments parents complete at six-month intervals throughout the program, and are designed to gauge the quality of stimulation and emotional supportiveness in EHS homes through a combination of semi-structured observation and interview items. They particularly focus on interactions such as parents' verbal responses to their child's vocalizations. Data from the 18-month parent assessment suggest that, overall, EHS children continue to live in nurturing home environments. On a 19-question scale in which a higher score represents a more nurturing home environment, the average score was 15.7, with individual scores ranging from 3 to 19 (Figure 7). The *Home Assessment* subset did, however, reveal a considerable decline in one aspect of parenting behavior. At 18 months into the program, fewer parents reportedly "spontaneously praised their child" than at 12 months into the program (57 and 79 percent, respectively).

Program nurses also periodically complete the entire 45-item *Infant/Toddler Home Inventory* (*HOME*) for each family. Each item receives a "point" if the behavior is observed during the visit or if the parent reports that the conditions or events are characteristic of the home environment, with a total possible score of 45. Data from these assessments appear to confirm

Figure 7

Home Environment After 18 Months in Program



that most EHS children continue to live in nurturing home environments, and indicate that for many children these environments had improved to a statistically significant degree during their time in the program.

For families with at least two reported *HOME* assessments, differences were analyzed between their initial score and their most recent one. For this group, the average score on the first *HOME* was 27, with individual scores ranging from 15 to 38. The average score on the second assessment was 31, with a range of 11 to 42. Scores improved for 28 families (67 percent) and remained the same for five (12 percent). Nine families registered lower scores on their second *HOME* assessment. In two of the nine families, a second child was born between the first and second assessment occasion; another family had two children at both assessment periods.

Another source of information about parents' relationships with their children comes from the *Parent-Child Activities* survey included in the EHS parent assessment battery. Parents were asked how often they had engaged in specific activities with their child during the previous month. Information was obtained from the primary caregiver—typically the mother—but if the child's father was also involved, questions were asked about his activities with the child as well. As a group, EHS mothers reported an increased rate of parent-child activities after each six-month assessment (six months, 12 months, and 18 months). Most notably, those parents for whom specific change scores were available between 12 months and 18 months showed a statistically significant increase in how frequently they engaged in these activities. For each item, the possible range of scores is 0 to 5, with 5 indicating more frequent activity and 0 indicating no activity; the average score was 3.6 after 12 months in the program, increasing to an average score of 4.0 after 18 months. Parents reported the greatest increases in how often they read to their children and how often they play outside (Table 4). These increases might be due in part to the program intervention (*e.g.*, emphasizing the importance of parents' reading to their children) and/or to the fact that the children are getting older (*i.e.*, the shift from one-year-olds to one-and-a-half-year-olds).

In general, involved fathers appear to be spending time interacting with their infants/toddlers in positive ways. Scores reported by mothers for their child's father at 18 months into the program averaged 3.6. Frequencies for individual father-child activities are displayed in Table 5.

Information about the development of adult-child relationships in EHS was also gathered using a *Parent-Child Observations Checklist*, a locally-designed observation instrument that is completed at six-month intervals. This instrument does *not* measure the specific behaviors in which a parent engages with their child. It is intended instead to provide a record of the family support specialist's judgement of parent-child relationships across a variety of domains over an extended period of time. Observations were reported in areas such as developmentally appropriate play, verbal interaction, discipline, and health care. Scores were calculated on a five-point scale, with five representing highly positive relationships. Overall, family support specialists' observations of families after 18 months in the program indicate that EHS

Table 4

Mother-Child Activities

0 = not at all
1 = rarely
2 = a few times a month
3 = a few times a week
4 = about once a day
5 = more than once a day

Activity	Average Score After 12 Months in EHS	Average Score After 18 Months in EHS
Sing songs	4.0	4.2
Read stories	2.7	3.5
Play outside	3.2	3.8
Tease to get him/her to laugh	4.4	4.4

Table 5

Father-Child Activities*

Activity	Frequency					
	Several Times a Week	Once a Week	A Few Times a Month	Several Times a Year	Once or Twice in Child's Life	Not at All
Reading or telling stories	13%	23%	27%	3%	7%	27%
Feeding	56%	16%	6%	9%	3%	9%
Eating a meal together	53%	13%	13%	6%	6%	9%
Going to the playground or for a walk outside	33%	33%	17%	3%	3%	10%
Playing at home	75%	6%	6%	6%	—	6%

*As reported by the mother on the 18-month assessment

(N=32)

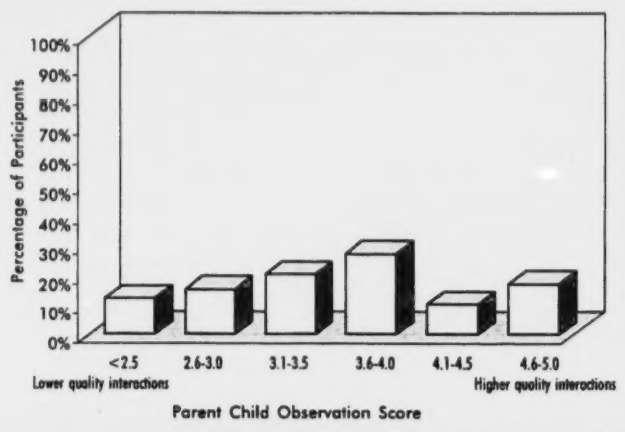
parents' engagement with their children falls across the distribution range from lower-quality interactions to higher-quality interactions, with almost half the families around the middle of the distribution. The average score for families assessed at 18 months into the program was 3.5, with individual scores ranging from 2.0 to 5.0 (Figure 8).

There was a small but statistically significant correlation between the observed quality of parents' interactions with their children and their knowledge of raising a baby. Parents whose relationships with their children were described as more positive were also those who communicated more knowledge of raising a baby.

Change scores for families on the *Parent-Child Observation Checklist* between 12 months and 18 months into the program reveal a downward trend in the percentage of families with higher-quality interactions and an increase in families with lower-quality interactions. Scores improved for 20 percent of these families, while 80 percent exhibited a decline. Several factors could have contributed to the change. While one possibility is that the EHS intervention hasn't had an impact on parent-child interaction, it is more likely that a combination of other factors came into play. Two possibilities include: 1) a change in assessment conditions, and 2) changes in family situations. First, family support specialists received additional training on the *Parent-Child Observations Checklist* early in the 1997-98 program year—a point

Figure 8

Parent-Child Interactions After 18 Months in Program



in time that fell between the 12-month and 18-month assessment for many families. This likely affected the way family support specialists subsequently completed the checklist—and contributed to some of the shift. Specifically, the training enabled family support specialists to refine their observation skills and attend to important features and nuances of parent-child interactions. Second, some parents gave birth to a second child between the time of their 12-month and 18-month assessment, adding an additional stressor to their relationship with their first child. In other families, infants moved into toddlerhood, a transition that is typically characterized by an increase in autonomy and the emergence of purposeful non-compliance. This developmental change is often accompanied by an increase in disharmony and conflict between parent and child.

Parents' self-reports about discipline provide additional evidence that they are struggling with the behavioral changes inherent in the transition from infancy to toddlerhood. The *Discipline* measure included in the EHS parent assessment battery presents parents with three examples of ways in which children can misbehave, and asks them to indicate what they would do in those situations. Parents are also asked if their child had been spanked in the past week due to misbehavior.

No major differences appeared between the 12 and 18 month assessments in responses to two items dealing with parenting issues that typically remain stable across the transition from infancy to toddlerhood—playing with breakable things, and eating. Responses to two items specific to typical toddler behaviors, however, revealed considerable change. Compared with the 12 month assessment, at 18 months into the program more parents were likely to report using inappropriate strategies to deal with tantrums. Moreover, twice as many parents reported that their child had been spanked during the past week. Due to these changes, overall discipline scores declined slightly for the 18 month assessment.

Despite these apparent emerging difficulties in parent-child relationships, family support specialists, when asked about changes in families over the course of the past year, spoke about parents' increased interaction with their children. More than one family support specialist commented that parents who hadn't originally wanted their children now had positive feelings about their families. Staff identified parent-child interaction and "giving families encouragement" as two of the most important things EHS does to help families. Similar sentiments were also articulated at the parent focus groups, where several parents described EHS as a program that supports young mothers and fathers. Said one mother: "[The program] helped my baby's dad—he started coming. It helped him as a father. He has a special bond now with the baby." Some also echoed another parent's statement: "[The program] helps me take better care of my child, raise him better." Others said that being in the program helped them with their parenting, and helped them with discipline.

Parent Mental Health

Phoenix Early Head Start services are designed to enhance the social and emotional development of the program's teen parents in order to support them in their role as primary caregivers. Program activities are intended to help parents develop appropriate decision-making skills, use effective coping strategies in stressful situations, and develop positive, age-appropriate social relationships. Parents' social and emotional well-being was appraised through a combination of established measures and EHS program data.

Participants in EHS often face a variety of stressful life circumstances. To gain some perspective about the stressful life events experienced by program parents, the *General Life Events* measure (adapted from Sandler, Reynolds, & Ramirez, 1986) was administered at enrollment and again after 12 months in the program. Parents were presented with 20 stressful life events and were asked to indicate which of these events occurred during the previous month.

At program enrollment and at their 12 month assessment, participants reported experiencing an average of five stressful life events during the preceding month. The events registering the

highest frequency of occurrence were consistent over time, as was the wide range in the number of stressful life events reported by individual participants. Some 20 percent of participants for whom data were available at each assessment period (N = 146 at enrollment; N = 67 at 12 months) reported experiencing eight or more of the 20 stressful life events. At the same time, four participants at each assessment occasion reported no stressful life events during the preceding month.

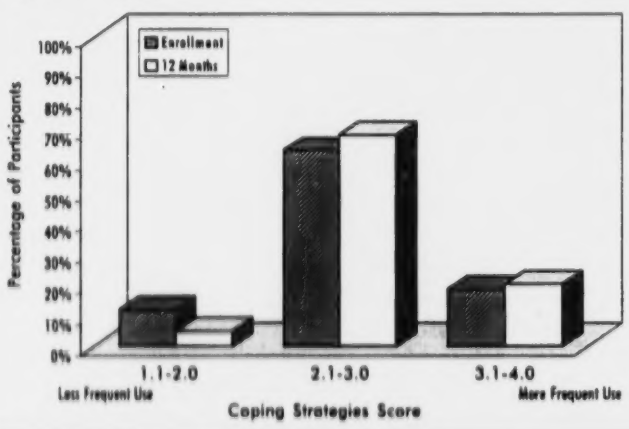
At enrollment and 12 months, more than half the respondents said that their parents had serious financial problems in the past month, and that their parents acted very worried, upset, or sad. At both assessment occasions, more than one-third of the participants also indicated that a close family member or someone they lived with committed a crime, got in trouble with the law, or was sent to jail. And, nearly 40 percent of both groups said that a close family member or a close friend had died in the past month (see Appendix C for response rates for individual life events for parents at 12 months into the program).

The use of positive coping strategies can help parents buffer the negative effects caused by some of the stressful circumstances in their lives. To assess this aspect of participants' mental health, the *Coping Strategies* measure was administered. This instrument is a compilation of 24 items from the *Children's Coping Strategies Checklist* (Preventive Intervention Research Center, 1992). The items represent young people's use of positive coping strategies—such as active problem-solving and positive thinking—to deal with stressful life situations (Ayers, Sandler, West, & Roosa, 1996).

For each statement, parents were asked to indicate the degree to which they used a particular strategy to deal with their problems in the previous month. Total scores range from 1 to 4, where higher scores indicate more frequent use of positive coping strategies. Responses indicate that participants are entering EHS with a moderate degree of positive coping skills, as scores average 2.7 and range from 1.4 to 3.9. Available data for parents assessed again after one year of program participation indicate that overall, their use of positive coping skills remained relatively steady, with a small decrease in the number of participants with fewer positive coping skills (Figure 9).

Figure 9

Positive Coping Strategies at Enrollment and After 12 Months of Program Participation



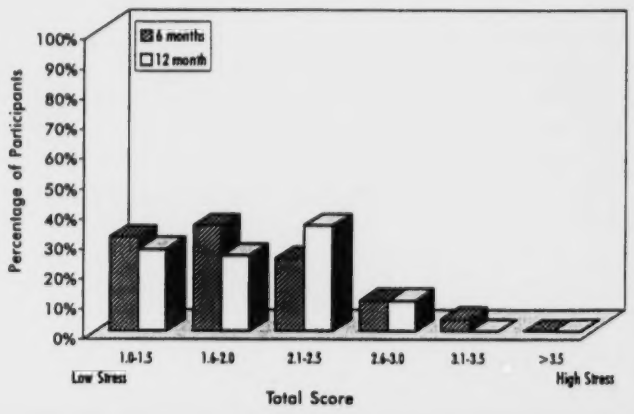
In addition to stress caused by general life events, it is also important to examine the stress associated with parenting, since research indicates that stress not only affects physical and psychological functioning, but also the quality of parenting. A *Parenting Stress Index (PSI)* is administered to participants whose children are at least three months old. This measure is composed of 13 statements reflecting parental distress and dysfunctional parent-child interaction. Parents were asked the extent to which they agreed with each statement as true of their parenting. Possible scores range from 1 (low parenting stress) to 5 (high parenting stress).

Overall, participants' stress related to parenting has remained low to moderate over time. Parents assessed at six months into the program and again after 12 months registered mean scores of 1.87 and 1.97, respectively. In addition, somewhat

higher stress levels expressed by a small group of parents at their six month assessment had dissipated by the time they had been in EHS for a year (Figure 10). The low to moderate stress pattern was also characteristic of a group of participants for whom data were available at 12 months and again after 18 months in the program. At all three assessment occasions (6, 12, and 18 months) parents continued to be most stressed about their [in]ability to handle things and their reduced ability to do things they enjoy.

Figure 10

Parenting Stress After Six Months and 12 Months of Program Participation



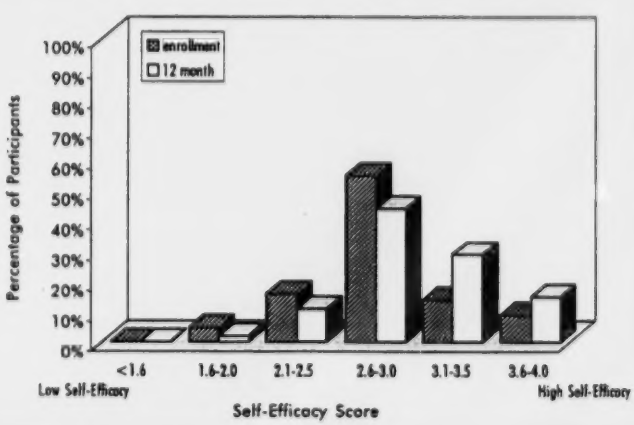
An individual's sense of control over, and responsibility for, the things that happen in their lives can help them deal with stressful situations and maintain psychological well-being. EHS participants' sense of control or self-efficacy was measured using a *Self-Efficacy Scale* (Mastery Scale, Pearlin, 1978, 1981). Parents were asked to indicate their level of agreement or disagreement with statements such as "Sometimes I feel that I'm being pushed around in life," and "What happens to me in the future mostly depends on me." Scores range from 0 to 4, with lower scores indicating low self-efficacy and higher scores reflecting high self-efficacy.

Parents who participated in EHS for one year evidenced a statistically significant increase in their self-efficacy scores. Available data for participants at enrollment and 12 months indicate that when they enrolled in EHS, parents generally had a moderate sense of control over their lives, and this sense of self-efficacy continued to increase during their first year in the program. The average self-efficacy score for these parents at enrollment was 2.8, with scores ranging from a low of 1.6 to a high of 3.9. After 12 months, their average score was 3.0, with a range of 1.9 to 4.0. The greatest change occurred in the groups with the two highest self-efficacy scores, an increase from 23 percent of parents at enrollment to 44 percent after 12 months in the program (Figure 11).

Self-esteem is another personal characteristic that contributes to people's psychological well-being and helps them deal with stressful life situations. Self-esteem was measured using an adapted form of the *Self-Esteem Scale* (Rosenberg, 1965). Scores on this scale range from 0, indicating high self-esteem, to 6, denoting low self-esteem. Overall, parents for whom data were available displayed moderately high self-esteem at both enrollment and after one year in EHS. The average score for

Figure 11

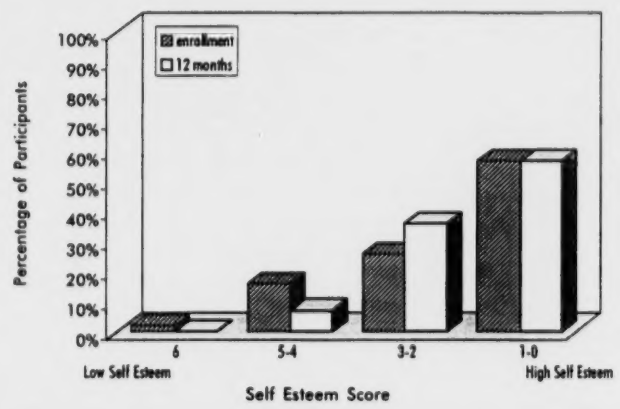
Self-Efficacy at Enrollment and After 12 Months of Program Participation



these participants at enrollment was 1.6, and after a year in the program their average self-esteem score was 1.4 (higher self-esteem). The proportion of participants with low self-esteem decreased between enrollment and 12 months, while there was an increase in parents with moderate self-esteem. The percentage of participants with high self-esteem remained steady from enrollment to 12 months (Figure 12).

Figure 12

Self-Esteem at Enrollment and After 12 Months of Program Participation



Additional information and insight related to parent mental health is available from family support specialists' assessments in the multi-disciplinary (MDT) team reviews as well as from parents' personal comments. Overall, MDTs for participants who had been in EHS for 18 months indicate that 71 percent of these parents were "engaging in age-appropriate positive social interaction," and that 66 percent were "not engaging in addictive behaviors." Available MDT data for parents across time (*i.e.*, at 6 months, 12 months, and 18 months), however, revealed an increase in participants' reported engagement in addictive behaviors and a decrease in age appropriate positive social interaction. Program administrators suggest that some of these reported changes might actually be reflecting improvement in the level of the relationships developed over time between the family support specialist and the parent, enabling the family support specialist to make a more accurate and honest assessment of what was going on in the parent's life. Changes may also be due to more accurate and specific reporting by parents. Revisions to improve the data collected on the MDTs occurred late in the year, but the EHS manager began guiding family support specialists in that direction earlier as part of weekly MDT sessions.

An added perspective to "parent mental health" can be gleaned from parent focus groups. Asked to describe how they had changed since being in EHS, and the most important things the program helped them with, parents articulated the personal help and support they received—and what that meant to them. One mother said she had been depressed before she was in EHS, and now "[I] always have something to do." Another remarked that "They counsel you right when you're thinking of doing something stupid. They help you get that out of your head." A third person commented that "It slowed me down—without the program I'd be in jail." A dad said he had learned that it's "not all that bad to be a father." Several parents talked more generally about how the program helped them with their problems, and some spoke about the EHS parent support group as a comfortable place to discuss personal problems.

Family support specialists similarly identified positive parent self-esteem, self-efficacy, and "pride" as important changes in program families over time. They described participants as more outgoing and more independent, and said parents had gained more exposure to their peers and had become empowered through their participation in activities such as the parent policy committee and policy council.

Parent Mental Health and Parent-Child Relationships

Some interesting correlations were found between indicators of parent mental health and parent-child relationships. Small but statistically

significant relationships appeared between parents' coping skills, stress levels, and their interactions with their children. Parents who reported more frequent use of positive coping strategies also reported more engagement in parent-child activities, and a home environment that was more nurturing. Parents who indicated lower stress also reported a more nurturing home environment, and they were also judged by family support specialists as having more positive interactions with their children (as assessed on the *Parent-Child Observations Checklist*). It is worth noting that, as in earlier program findings, greater knowledge of raising a baby was related to lower parental stress. Parents with greater knowledge of raising a baby also had better coping skills.

Indicators of parent mental health also appear to be intercorrelated. Parents with higher self-esteem and higher self-efficacy indicated lower levels of parental stress and appeared to have more positive coping skills. A small but significant relationship also exists between positive coping skills and lower parental stress.

Personal Health Care Practices

Family health and wellness is promoted in EHS through ongoing monitoring of health issues during home visits, linkages to community health care providers, and site-based group activities. Desired program outcomes focus on routine and preventive health care practices, prenatal and postnatal care, and family planning.

Nearly two-thirds of the parents for whom data were available after 18 months in EHS said they had received services from the Arizona Health Care Cost Containment System (AHCCCS)—the state's indigent health care program—during the previous six months. A similar proportion of participants also reportedly sought appropriate medical care for health problems, and more than 50 percent used preventive health care services (e.g., well-woman exams). In addition, 60 percent of parents were reported to utilize some form of family planning. As discussed earlier, this information is based on the original version of the MDT form, and therefore subject to some problems due to lack of item specificity and clarity. While very limited information was available from the revised "MDT-2" form at the time of this report, the data appear to reflect similar proportions of parents practicing preventive health care, preventing unplanned pregnancies, and seeking appropriate care for their health problems.

Educational and Economic Self-Sufficiency

One of the goals of Phoenix Early Head Start is to help families move towards long-term self-sufficiency. The strategy for doing this includes a focus on both education and employment, since many of the parents are young teens who are at risk of not completing their education. When they entered EHS, half of the parents indicated that they had already dropped out of school. Program services are intended to help parents lay the foundation for long-term economic independence through education and/or the acquisition of job skills. Some tracking of participants' progress in these areas occurs during the multi-disciplinary team reviews.

Data from the 18- month MDT reviews indicate that overall, more than half of the participants for whom data were reported had attended some type of educational or job training program during the preceding six months. In addition, more than a third reportedly held a full time job some time during that time period. A subset of participants for whom trend data were available at 6, 12, and 18 months into the program (N=32) reflected some movement from participation in education/job training to full-time employment during that time. At six months into the program, 28 of these participants (88 percent) were attending school or some type of job training. After 18 months in EHS, only 19 individuals in this group (59 percent) were reportedly in school or job training. Available data for eight of the people who had moved out of the "school/job training" category indicate that seven had worked at a full time job some time during the prior six month period. Problems of item specificity on the original MDT form, however, make participants' status prior to taking the job unclear (i.e., it is difficult to know whether these parents completed school/job training or dropped out).

This type of information, along with more specific details about subsequent work will be captured in the recently-implemented MDT-2 forms. As discussed in the previous section, available MDT-2 data at the end of the 1997-98 program year were extremely limited. Of 18 participants for whom data were available, two had completed their GED, one had graduated from high school during the six months prior to the MDT review, one was attending a community college, and several others had progressed to the next grade level or were still attending school. Two others had stopped attending school during the reporting period. Information about job stability indicated that over the six-month reporting period three participants who had been working remained in the same job, two stopped working, and three people had changed jobs—once, three times, and four times, respectively.

Several elements in addition to employment contribute to progress towards long-term self-sufficiency, including availability of adequate housing and child care. Information for some of these elements, gathered from 18- month MDTs, is delineated in Table 6. The earlier caveat regarding the non-specific nature of some of the information from the original MDT forms also applies here.

Information from parents provide some additional insight about program services in the areas of education and employment. When asked about the most important things with which EHS had helped them, several parents mentioned the support they had received in developing and working toward goals, such as getting back into school, obtaining their GED, completing high school, getting referrals to jobs, and writing resumes. As one parent commented, "One [goal] was to finish school. Problems put me back. EHS helped me get on track again." While EHS was able to help in many areas, three parents discussed problems finding employment due to their "undocumented" status. Nevertheless, nearly 70 percent of EHS parents who completed a parent survey "strongly agreed" or "agreed" that the program helps them do better in school or work. An additional 21 percent indicated that the statement didn't apply to them.

Another factor associated with becoming economically self-sufficient is literacy level. At program entry, more than 25 percent of parents described their English speaking and reading skills as "somewhat adequate" to "inadequate." On a different assessment instrument after one year in the program, 13 percent of parents reported some difficulty reading (in their primary language) things such as directions for medicines and labels on food packages. When asked how often they read at home, 25 percent of parents responded "a few times a month" or less.

Summary

Most indicators of parent-child relationships continued to be positive or showed improvement in 1997-98. For example, parents displayed a significant increase in their knowledge of raising a baby between the time of their enrollment and an assessment after 12 months in the program, particularly in their knowledge of realistic and developmentally appropriate expectations for their infant's behavior. In addition, data from parents, family support specialists, and nurses indicate that EHS children continue to live in nurturing home environments, and that in most cases this environment appears to be improving. Furthermore, mothers reported overall increased rates of

Table 6

Selected Indicators of Self-Sufficiency: Participant Status at 18 Months in Program*

Indicator	% of Participants
Employed part-time	21%
Employed full-time	36%
Living in adequate housing	84%
Access to and utilization of quality child care	68%
Using effective household management and budgeting skills	64%

(N=56)
*Based on staff report with parent input.

parent-child activities after each six-month period in the program, particularly in regard to reading to their children and playing outside together.

Some exceptions to the generally positive indicators of parent-child relationships are noteworthy, however. First, many parents appeared unable to generalize their knowledge of raising a baby to their toddlers, and they exhibited inappropriate expectations for toddler behavior. Second, some decline occurred in the frequency of parents praising their children. Third, while increased interaction is generally considered a positive indicator, not all interactions are equal in value. Family support specialist observations of the quality of parent-child interactions showed that families' interactions were distributed across the spectrum from highly positive to less positive. But comparing observations made of families 12 months into the program to those at 18 months shows a decline in the percentage of families with higher-quality interactions and an increase in families with lower-quality interactions. These changes might be attributed to a variety of factors, including training for family support specialists that refined their observation techniques, stress due to the addition of a second baby in some families, and stress for parents as a result of their child's transition from infant to toddler. Difficulty in adjusting to the increased autonomy and purposeful non-compliance characteristic of toddlers may also explain why more parents reported spanking their children and using inappropriate strategies to deal with tantrums after 18 months in the program compared to earlier.

EHS parents face many life stressors besides the stress associated with parenting. On surveys, they continue to report relatively high numbers of other stressful events in their lives— an average of five events each during the preceding month. Nevertheless, the overall mental health status of EHS parents appears to be fairly stable: their use of positive coping skills has remained at a moderate level, self-reports of parenting stress have remained low to moderate, parents' sense of self-efficacy has increased, and parents' self-esteem has remained moderately high. In addition, most parents reportedly appear to be engaging in positive social interactions and not engaging in addictive behaviors— though change data show some decline in these two indicators, possibly due to parents' increased comfort in giving more accurate and honest reports to their family support specialists.

Analysis has revealed some small but significant correlations between parent mental health and parent-child relationships, and also between parent mental health and knowledge of raising a baby. These are:

- More frequent use of positive coping strategies by parents is related to higher reports of parent-child activities and also to reports of a more nurturing home environment.
- Lower parental stress is related to reports of a more nurturing home environment and also to observations of more positive interactions with children.
- More knowledge of raising a baby is related to lower parental stress and also to more frequent use of positive coping strategies.

The program focus on parents' personal health care practices, and on their educational and economic self sufficiency, appears to be producing positive results. Nearly two-thirds of parents for whom data were available after 18 months in EHS had received medical services through AHCCCS (the state's indigent health care program) in the previous six months, and more than half had practiced preventive health care and used some form of family planning. Among these same parents, more than half had also attended an educational or job training program in the previous six months, and more than a third had worked a full-time job. Available data also suggest that some of those in job training programs had transitioned into full-time jobs at some time during the previous six months. Difficulties with literacy (either in English or in the parent's primary language), however, continue to affect some EHS parents, and this is likely to present an obstacle to their future educational and economic improvement.

■ ■ ■

Child Services and Outcomes

Phoenix Early Head Start program services are designed to create a safe, stable, and supportive emotional and physical environment for children, and also to enhance their opportunities for long-term intellectual, social, emotional, and physical development. Through EHS services, parents are encouraged to provide developmentally appropriate activities for their infants and toddlers, and they are supported in doing so in several ways. Family support specialists employ modeling and coaching techniques during home visits to help parents learn to interact with their children using developmentally appropriate strategies. Parents also attend site-based activities that frequently focus on aspects of early childhood development. Weekly parent-child play groups facilitated by the child development/disabilities specialists further emphasize parent-child relationships including play skills, language, and developmental sequencing.

The child development/disabilities specialists provide support for children in EHS with special needs. Children with suspect or confirmed developmental delays are particularly encouraged to participate in the weekly parent-child play groups. Additional services include referrals for further assessment, consultation with families and/or the family support specialists, and coordination of community resources to expedite intervention services. Special needs families receive home visits from the disabilities specialist until outside services are in place.

Two full-time registered nurses also provide child health and development services. They visit each family at least twice a year to assess the physical and developmental status of each child, and they attend many of the program activities where they are available to talk with parents about child health issues.

By design, the major EHS intervention focus is on child and family development. As mentioned earlier, these issues accounted for 56 percent of the services during visits with families. Because the child and family development "umbrella" of program services includes a variety of topics/issues, this category can be addressed more than once during a single family visit. Over the past year, child and family development issues were addressed, on average, three times during each visit.

Parent-child play groups during the past year have also provided rich opportunities to support positive child development and healthy parent-child relationships. More than a quarter of all parents enrolled in the program during the last year attended at least one play group session. On average, these parents attended 2.7 play group sessions, with individual parents' attendance ranging from one to nine sessions each.

Program goals and desired outcomes for children in Phoenix Early Head Start extend over four domains: infant-toddler development, developmental delays or disabilities, healthy parent-child relationships, and infant-toddler health. A review of children's status and/or progress in these areas is presented below.

Infant-Toddler Development

Infants and toddlers in Phoenix Early Head Start who do not have developmental delays or disabilities are expected to demonstrate age-appropriate development in all domains. The program addresses and categorizes child development services within six areas: cognitive, speech and language, social/emotional, gross motor, fine motor, and self help.

One program measure used to assess children's developmental status is the *Infant-Toddler Developmental Assessment (IDA)*. Programmatically, this instrument was designed to be administered

when the child is 12 months old, then again at 24 months and 36 months of age. For evaluative purposes, a total "developmental score" is calculated for each child, with higher scores denoting higher functioning (maximum score=6). At the time of this report, 12- month scores were available for 68 children. Among this group, the average *IDA* score was 5.0, with individual scores ranging from a low of 1 to a high score of 6.

At 12 months, needs and concerns were identified for 30 of the 68 children (44 percent), with an average of two areas of need/concern registered for each. While there were some concerns registered in each developmental category, speech and language was by far the most problematic, with close to 40 percent of the reported needs/concerns falling into this domain. Although limited, available *IDA* data for children at 24 months of age appear to be following the same pattern, with speech and language concerns registered for more than half of the children who were assessed at that time.

Programmatically, a "concern" identified in the IDA is expected to trigger some notice on the family's individual family service plan—and therefore influence the services that a family receives. Analysis of program data for children with concerns in speech and language reflects a trend in the right direction. Although not a statistically significant relationship, families of children with speech and language concerns had a greater proportion of their home visits focused on speech/language issues than did families with children screened as "competent" in this domain (62 percent and 55 percent respectively).

Overall, most parents feel that EHS is helping their children's development. More than 80 percent of respondents on the parent survey strongly agreed or agreed that "my child is better off because of EHS." Information from parent focus groups confirms this sentiment. One parent described EHS as a program that "gives babies developmental skills," and another simply said "they work with the children." Several parents said their children were happier, and commented that the monthly socialization activities and play groups helped their babies learn to get along with other children. These feelings were captured by one mother who, when asked how her child had changed since being in EHS, replied that "my baby was selfish. [S/he] couldn't interact with other babies...it's better now."

Developmental Delays or Disabilities

The desired program outcome for infants and toddlers in EHS who are identified with potential developmental delays or disabilities is that they are referred to and receive appropriate intervention services and show developmental progress. One of the screening instruments used by EHS to identify children with developmental concerns is the *Denver II*. This is administered by the program nurses, who typically screen at birth-45 days, then again around 6 months, 18 months, and 30 months of age. Reported results fall into three categories: "within normal limits," "suspect," or "untestable." A child screened as "suspect" might be referred for further testing or re-tested, depending on the degree of suspicion. A child who does not cooperate with the testing process is reported as "untestable."

The *Denver II* screenings identified few children with developmental delays. Screening tests administered when infants were between four and eight months old (N=94) indicate that 94 percent of the children scored within normal limits, and six percent were considered "suspect." Of the children screened between 16-20 months old (N=44), one child was "untestable" and the rest were within normal limits.

While the low number of EHS children identified with developmental delays might appear surprising, two factors could account for some of these results. First, the *Denver II* was not administered to children who had already been diagnosed with developmental delays. Second, the instrument is generally considered to have very low sensitivity—it tends to identify only those children with obvious developmental delays (Meisels & Wasik, 1990).

Phoenix Early Head Start children with possible developmental delays are also identified through concerns raised by family support specialists. Depending on the level of concern, some of these children are referred to the EHS child

development/disabilities specialists or to services outside the program. According to information from MDT reviews during the past year, the families of 16 children who were identified by staff with possible developmental delays and referred for further testing or services had followed through on the referrals.

Healthy Parent-Child Relationships

One of the desired outcomes central to the EHS program intervention is that infants and toddlers in the program show evidence of a healthy relationship with their parents. Parental beliefs, attitudes, and behaviors associated with healthy parent-child relationships were analyzed in the earlier discussion of adult-child relationships. This section will focus on specific parent-child interactions, child behavior, and assessments of the overall quality of these relationships.

An important indicator of the overall quality of the parent-child relationship is the effectiveness with which the two interact. Family support specialists were asked to gauge the quality of parent-child relationships for each of their families based on their observations. They "agreed" or "strongly agreed" that after 18 months in the program, 83 percent of the children were "using positive strategies to seek out their parents." At the same time, they "agreed" or "strongly agreed" that 68 percent of parents "supportively respond to their child's calls for attention." These ratings suggest that most EHS children feel confident in their own ability to elicit their parent's attention, and in their parent's responsiveness. The ratings further suggest that family support specialists believe the parent-child interactions of the majority of EHS families are effective and harmonious.

Family support specialists were also asked to characterize the overall emotional tone of the parent-child relationship, and to rate the relationship overall. Parent-child relationships were described as "supportive/positive" for 63 percent of the families for whom data were available at 18 months into the program. Nearly 20 percent of relationships, however, were characterized as "anxious/intrusive," and 17 percent were considered "hostile/ambivalent." In addition, family support specialists rated the overall relationship between the parent and child as "average" for nearly half the families, while 27 percent of the relationships were described as "above average" and 24 percent as "below average." This represents a considerable decline from family support specialists ratings at the 12-month assessment.

Once again, two factors could account for this change. The training on the *Parent-Child Observation Checklist* that family support specialists received between the 12 and 18 month assessment focused on qualitative features of parent-child relationships. It would be expected that family support specialists would be more sensitive to these features during the 18 month assessment and, therefore, more likely to discriminate accordingly. Specifically, they might have been more able and likely to identify the characteristics of "hostile/ambivalent" and "anxious/intrusive" relationships. It is also possible, however, that these differences are consistent with other data suggesting that the transition to toddlerhood poses a significant challenge to the parent-child relationships in EHS families. In addition to affecting some specific features of the relationship described earlier in the report (*e.g.*, discipline), this transition might have negative consequences for the overall quality of the relationship as well.

Infant-Toddler Health

Phoenix Early Head Start services and activities are designed to help ensure that infants and toddlers are physically healthy and safe. Program data for families who have been in EHS for 18 months indicate that a large majority have continued to follow through with the health care activities necessary to keep their children healthy; nevertheless, room for improvement still exists (Table 7). As reported on the 18-month MDT reviews, 11 percent of children are not up-to-date on their immunizations, and 18 percent are not up-to-date on well-baby/well-child checkups. Staff also indicated that 18 percent of children had not received appropriate treatment for health problems they were experiencing.

Table 7

Child Health Care: 18 Month Family Review

Health Care Activity	% of Children
Recommended immunizations	89.3%
Recommended well-baby/well-child checkups	82.1%
Appropriate treatment for health problems	82.1%

Ensuring that children have a safe home environment is another important element of child well-being. Available data related to home safety were mixed. Appraisals on 18-month MDT reviews indicate that EHS staff felt that more than 40 percent of families for whom information was available were *not* providing a safe home environment. Parents' self-reports, on the other hand, were more positive.

Information about parents' knowledge and self-reported use of safety precautions, which is also gathered as part of the semi-annual parent assessment batteries, indicates that parents assessed during their second year in EHS appeared to be doing better in the area of safety than those who were assessed during their first year in the program. Furthermore, for a subset of parents for whom data were available after 12 months and 18 months in the program, there are also some changes in a positive direction during the past year (Table 8). In general, these data provide some indication that families are concerned with their children's safety, and specifically that a large percentage are using some form of child restraints while driving and have smoke alarms in their homes. One area is of particular concern, however, suggesting a need for increased knowledge and awareness. Fewer than half the parents (on their 18-month program assessments) said they had covers on their unused electrical outlets—although their children are at an age when they are mobile and curious. Another issue that suggests room for improvement is knowledge of whom to call if a child ingests something dangerous. Nearly 20 percent of parents said that in this situation they would "look up" the phone number (rather than calling 911 or already having the poison control number available).

Table 8

Safety

	12 Month Assessment	18 Month Assessment
If you had to get the phone number of the poison control center in an emergency, do you know how to find it?		
Yes	91.5%	91.5%
What would you do?		
Call 911	34.9%	37.2%
Look it up	16.3%	18.6%
Have available	27.9%	34.9%
Search for number	4.7%	—
Other	16.3%	9.3%
Do you have covers on all your electrical outlets that don't have plugs in them?		
Yes	42.6%	48.9%
Does your home have smoke alarms?		
Yes	63.8%	72.3%
When you take your child in the car, what kind of child restraints do you use?		
Car seat	89.1%	85.1%
Parent's lap	6.5%	6.4%
No restraint	—	2.1%
Seat Belt	4.3%	6.4%

Summary

Child development constitutes a primary focus of the EHS intervention, accounting for a large percentage of services rendered by staff during home visits and during parent-child play groups offered at EHS sites. Most parents appear to appreciate this focus, and feel that their child is better off because of program services.

Ratings of developmental status for 12-month-old children in the program indicate they are doing well on average. Most identified developmental concerns fall in the category of speech and

language. For those children for whom concerns were identified as part of their developmental status rating, program records indicate that these concerns triggered increased emphasis on that area during home visits. EHS children with possible developmental delays are also identified by family support specialists during the course of regular program activities, and last year the families of 16 of these children followed through on program referrals for further testing or services.

Children in EHS show generally positive relationships with their parents. Family support specialists' observations of families after 18 months in the program indicate that most parent-child interactions are effective and harmonious. However, the overall emotional tone of these relationships was characterized less positively, with nearly 40 percent of relationships described as anxious/intrusive or hostile/ambivalent. Also, ratings of the overall quality of parent-child relationships after 18 months in the program have declined since earlier observations made 12 months into the program. Two factors might have influenced this change: the stresses caused by an infant's transition to toddler, and training on parent-child observation techniques that increased family support specialists' sensitivity to qualitative features of parent-child relationships and their ability to make appropriate distinctions.

Health and home safety issues continue to cause some concerns. While most parents have continued with appropriate health care practices, some have not kept up with well-baby/well-child checkups or kept their children's immunizations current. Furthermore, a large percentage of families for whom information was available were reportedly not providing a safe home environment. In general, however, parents report an increase in their knowledge and awareness of safety this year over last, but some safety performance areas— such as covering unused electrical outlets and knowing who to call in case of poisoning— still offer considerable room for improvement.

■ ■ ■

Staff Training and Outcomes

Phoenix Early Head Start embraces the staff development cornerstone of the national Early Head Start program because program managers recognize that staff need fundamental grounding in basic knowledge and skills in order to serve the program's target population. A set of training goals has been developed to bolster staff knowledge and skills in the following four key areas:

- child development and parent-child relationships
- supportive alliances with families
- appropriate strategies for working with adolescent parents
- "core" knowledge necessary to implement EHS program services

During the 1997-98 program year, family support specialists attended trainings in all four key staff development areas. These will be discussed later in this section. Other EHS staff also attended trainings in other related areas (*e.g.*, reflective supervision), but because the subject of these trainings falls outside the scope of this evaluation, they will not be analyzed.

Outcome data for staff training were collected by several methods: surveys, interviews, focus group discussions, and assessments of staff knowledge and skills. In addition, program documents were reviewed for additional background information. Staff were also asked to complete a brief evaluation of each individual training session they attended, on which they rated the training's "usefulness" as well as their own knowledge of the subject area addressed.

While many staff members besides family support specialists also attended training sessions (*e.g.*, site supervisors, nurses, and the male involvement specialist), only the ratings of the family support specialists are analyzed for this report, since the wide range of professional training and experiences among other staff members makes meaningful comparisons difficult to render. Furthermore, ratings are analyzed only for those training sessions that had two or more family support specialists in attendance.

The subsections that follow summarize staff training activities and results for each of the four desired outcome areas for the 1997-98 year.

Child Development and Parent-Child Relationships

A primary cornerstone of Early Head Start is to "enhance and advance" the successful development of each child in the program. The quality of the parent-child relationship is considered to be a critical factor in this development because parents provide much of the emotional support, engagement, and continuity considered necessary for an infant's healthy growth and acquisition of skills (Advisory Committee on Services for Families with Infants and Toddlers, 1994).

Building expertise in the area of child development and parent-child relationships has been identified as a priority of Early Head Start staff training. With the knowledge and skills that family support specialists gain from their training, they are expected to regularly monitor the development process of each child and to support positive parent-child relationships through home visits, referrals, and other activities.

Issues of child development and parent-child relationships were addressed during the 1997-98 year by a total of nine trainings—more than for any other area. These trainings covered topics such as parent-child observation techniques, the importance of male involvement in child development, issues of early childhood development, how to deal with difficult children, and methods of nonviolent child

discipline. Five of these trainings were rated by two or more family support specialists.

Ratings for the trainings were high: on a five-point scale in which 5.0 signifies staff "strongly agree" that the training was useful (i.e., that it was worthwhile, they learned from it, and they will use what they learned) each of the training sessions received an average score of 4.2 or better (Table 9). Among the most highly rated trainings was a session on parent-child observation (rated 4.7 overall) which, according to participant comments, effectively used videotape examples of parent-child interactions to help family support specialists identify the types of cues they should look for during home visits. Two other highly rated trainings dealt with nonviolent methods of child discipline (rated 4.7 and 4.5 overall), a priority area for EHS. Typical comments on the discipline trainings praised the "opportunity to share specific case situations," the informal question and answer sessions, and the video and verbal examples that were presented. The training on male involvement drew praise for the speaker's presentation of the effects of male involvement on children, strategies to encourage involvement, and the differences in parenting style that fathers have. One aspect of the training that had particular impact, according to family support specialists, was a videotape that showed "children talking about their fathers."

To explore how well staff recalled important concepts presented during training sessions, a new instrument—the *Staff Knowledge Assessment*—was implemented with family support specialists this year. Questions contained in the assessment were developed by the presenters of selected training sessions. Concerns, however, about the validity and reliability of some subsets of questions led to a decision to focus this year's analysis exclusively on a group of questions that specifically assessed child development concepts presented in a SWHD child development course attended by the family support specialists.

On this subset of questions, family support specialists scored an average of 8.3 out of a possible 11 points, with individual scores ranging from 5.0 to 10.5. Comparing individual scores with the length of time a family support specialist was employed by EHS reveals no pattern favoring longer tenure, but the data suggest that prior education and experience likely play a strong role in a family support specialist's knowledge of child development concepts. It should also be noted that some of the longer-term family support specialists had not attended this child development course during the 1997-98 year, but in a prior year, hence the information on concepts may not have been as fresh for them.

In examining the effectiveness of EHS staff training, one of the key questions must be—Did the training make a difference with families? To help answer that question, family support specialists were tested on their ability to apply their knowledge of parent-child relationships and infant/toddler development, using a new instrument, the Phoenix Early Head Start *Staff Video-clip Analysis*. The instrument was developed by EHS/SWHD managers and child development specialists in collaboration with program evaluators. It was designed specifically to evaluate staff knowledge and skills in areas considered essential to achieving desired program outcomes for infants/toddlers and families.

For the video-clip analysis, family support specialists viewed two separate video examples of actual parent-child interactions: a mother with a 9-month-old child, and a mother with an 18-month-old child. On

Table 9

Staff Training: Child Development/Parent-Child Relationships

Training Session	N	Training Was Useful*
Parent-Child Observation	7	4.7
Male Involvement	4	4.6
Dealing with Difficult Children	2	4.2
Discipline	8	4.5
Non-Violent Discipline	7	4.7

*Training was worthwhile; staff learned from training; will use what was learned.
Ratings: Scale ranges from 5 = Strongly Agree to 1 = Strongly Disagree

two key areas—child development and parent-child relationships—family support specialists were asked to identify the most critical strengths, the most critical concerns, and the areas needing further assessment. Then they were asked to list objectives, activities, and indicators of progress they would use for each family. All responses were compared to an answer key developed by the ad hoc evaluation group.

Two scores were obtained for each family support specialist on each video-clip. The exemplar score totals the number of correct *examples* of a concept or key issue that the family support specialist was able to identify. The conceptual score totals the number of times the family support specialist actually named the *concept* or key issue underlying an exemplar. Results are reported for family support specialists who had been working in EHS longer than three months (Table 10).

Table 10

Staff Videoclip Analysis: Child Development and Parent-Child Interactions

	Range of Scores	
	Exemplar	Conceptual
Clip 1: 9-month-old child	4-18*	1-5*
Clip 2: 18-month-old child	8-21**	2-8**

*maximum possible score = 27 ** maximum possible score = 30

Note: Exemplar score—staff identified an example of the concept
Conceptual score—staff identified the concept

For the video-clip analysis involving the 9-month-old child, the number of exemplars identified by family support specialists ranged from 4-18 out of a possible 27, and the number of identified concepts ranged from 1-5 out of a possible 27. Comparing scores to length of employment in EHS shows that family support specialists employed for more than a year scored somewhat higher than the average for the whole group, identifying 13 exemplars (48 percent) and 3 concepts (11 percent).

For the video-clip analysis involving an 18-month-old child, family support specialists identified a range of 8-21 of 30 possible exemplars, and 2-8 of 30 possible concepts. Family support specialists with 3 to 12 months of EHS employment scored higher than the group average on exemplars, identifying 15 (50 percent), but no group scored substantially higher than average in identifying concepts.

Overall, results on the video-clip analysis suggest that family support specialists' ability to identify examples of strengths and concerns for both child development and parent-child interactions exceeded their ability to identify the underlying conceptual issues. Furthermore, their ability to identify exemplars and concepts was better with respect to older infants than younger ones.

Data collected from surveys, interviews, and focus group discussions also addressed the effects of training in this area. Program supervisors and managers who were interviewed said that staff had increased their focus on child development during home visits this year compared to last. On staff surveys of knowledge, most family support specialists rated their knowledge and/or training in this area as "extensive" or "moderate." In interviews and focus groups, however, family support specialists expressed more variety of opinion with regard to their practical knowledge. Several concurred with a comment that "it's hard to come up with specific activities to do with [individual] families." They said they considered the SWHD child development course to be highly informative, but agreed that more frequent training in this area was necessary. They also suggested regular follow-up on staff training sessions as part of their ongoing supervision in order to reinforce and extend concepts learned. Male involvement was also singled out as a topic in need of more training because family support specialists have increased their work directly with fathers. In light of this change, they suggested a shift in focus from "how to work with the male involvement specialist" to "how to work with fathers." Overall, most felt the program needed a defined training curriculum to address child development and parent-child relationships. They predicted that a curriculum would act as a stabilizing factor for the program in two ways: it would help bring new staff up to speed quickly, and provide a reference for continuing staff.

In interviews, program supervisors and managers agreed with family support specialists regarding

the value of a program curriculum as a way to help staff "pass on" their knowledge to families, but no specific action had been taken prior to the end of the program year. They also indicated that supervision and videotaping were addressing some of these issues.

Supportive Alliances With Families

Effective family interventions begin with supportive, nonjudgmental, and empathic relationships between service providers and their clients (Nezworski, Tolan, & Belsky, 1988; Schrag, Fenickel, & Eggbear, 1990; Ware, Osofsky, & Leitchman, 1987). For interventions involving infants or young children, the quality of the provider-parent relationship is considered a key determinant of success—positive relationships with program staff can strengthen a parent's feelings of acceptance and appreciation which, in turn, can foster positive parent-child relationships (Kalmanson & Seligman, 1992).

Five trainings during 1997-98 focused on developing supportive relationships with families. These included sessions dealing with setting boundaries, relieving stress, using reflective supervision, learning basic Spanish terms for medical personnel, and creating a state plan for working with parents of children with disabilities. Two trainings were rated by two or more family support specialists. Overall ratings for the training sessions were high, ranging from 4.3 for the session on stress to 4.8 for the session on boundaries (Table 11).

Table 11

Staff Training: Building Supportive Alliances with Families

Training Session	N	Training Was Useful*
Boundaries	8	4.8
Antidotes for Stress	2	4.3

*Training was worthwhile; staff learned from training; will use what was learned. Ratings: Scale ranges from 5 = Strongly Agree to 1 = Strongly Disagree

The boundaries training, in particular, stimulated a number of thoughtful comments by the eight family support specialists in attendance, and apparently clarified some issues. Typical comments praised the training for the interactions that it stimulated, for the discussion and self-evaluation that took place regarding values and beliefs, and for the opportunity it allowed participants to ask questions. Said one family support specialist regarding what was learned: "...I really blew it in some cases... I will try to fix some of my mistakes." Said another: "It really made me think about boundaries, both professionally and personally."

In interviews and focus groups, the topic of setting appropriate boundaries continued to generate discussion. Family support specialists reiterated their opinion that the training was helpful, but said they perceived lack of consensus among supervisors and managers on this subject, and continued discussion was needed to clarify the issue.

Site supervisors also indicated some concern regarding boundaries. On the Supervisor Survey regarding individual staff members, one family support specialist was rated low on the subject of "appropriately boundaried" relationships with families. This subject was a concern of supervisors last year also, and since then two former family support specialists encountered difficulties setting appropriate boundaries. According to one supervisor, "Boundaries will continue to present challenges as family support specialists become more deeply involved with families."

In other areas, ratings were high. On those staff survey items that assessed supportive alliances, family support specialists either "strongly agreed" or "agreed" with most key program concepts (*e.g.*, collaborative planning, genuine and authentic interactions). Responses on parent surveys also suggest that family support specialists are building supportive alliances with families. On 15 survey items addressing the quality of the parent-family support specialist relationship, parent responses were highly positive overall. Moreover, when parents are grouped according to time in the program (*i.e.*, less than six months, 6-12 months, more than 12 months) their positive responses show an upward trend as their duration increases,

suggesting that the parent-family support specialist relationship strengthens with time. The increase in positive responses is statistically significant for parents who had been in the program more than 12 months compared to those with less than six months of program participation.

Strategies For Adolescent Parents

One of the unique challenges facing family support specialists in pursuing the goals of the Phoenix Early Head Start program is that parents in the target population are adolescents. In order to encourage better child and family outcomes for their clients, therefore, family support specialists must possess both a solid grasp of adolescent development, and a portfolio of effective strategies for working with a teenage population.

Four training sessions during 1997-98 were related to strategies for working with adolescent parents. Trainings covered subjects such as working with pregnant teens and teen parents, understanding the stages and behaviors of adolescence, making use of services and programs for teen parents, and helping adolescents to make positive choices in life. Two of these trainings were rated by more than one family support specialist, and their ratings were high, ranging from 4.4 to 4.7 (Table 12). One training session, "Demystifying Adolescence," in particular, was praised by family support specialists for teaching them about the different stages of adolescence, how to better communicate with teens, and how the juvenile legal system works. Several commented that they liked the interactive style of the training, and suggested that more time be devoted to this particular training and subject matter. One family support specialist wrote: "I learned a great deal working as a team on projects during this training."

Table 12

Staff Training: Strategies for Working with Adolescent Parents

Training Session	N	Training Was Useful*
Demystifying Adolescence	11	4.7
Florence Crittendon Conference	3	4.4

*Training was worthwhile; staff learned from training; will use what was learned.
Ratings: Scale ranges from 5 = Strongly Agree to 1 = Strongly Disagree

In interviews and focus groups, family support specialists reiterated that the "Demystifying Adolescence" training was valuable. They also found it to be an effective team-building exercise because EHS brought in a presenter to train them as a group. Echoing last year's comments, they indicated a continuing need for training on adolescent issues.

Staff survey results suggest that staff believe they improved their skills in working with teen parents. On items regarding risk and protective factors for their clients, most family support specialists rated their knowledge and/or training as "moderate"—an increase over the previous year when one-third had rated themselves as "barely adequate" on two of the items. Supervisors' ratings of staff agree that family support specialists are using appropriate strategies (*e.g.*, intervention activities that are age-appropriate for teen parents; information that the client can understand) to work with teen parents. Parent surveys also support this finding. When asked to rate statements regarding the appropriateness of family support specialist strategies (*e.g.*, the parent understands what the family support specialist is saying; most suggestions from family support specialists are helpful) an overwhelming majority of parents responded that they "strongly agree."

Core Knowledge

In order to implement EHS program services, family support specialists must have basic knowledge of adolescent health and development, family planning, perinatal and well-child care, and community-based services and resources. All of these areas will be analyzed under the category "Core Knowledge," with the exception of adolescent development, which was discussed earlier under the category "Strategies for Adolescent Parents."

Six training sessions addressed subjects considered to be part of the core knowledge of EHS staff.

Among these were sessions on CPR and first aid, sun safety for adults and children, national program standards for EHS, services for children with disabilities, techniques to improve literacy through creative writing exercises, and ways to recognize and understand gang-related behaviors. Three of these training sessions were rated by more than one family support specialist. Each one received very high ratings, ranging from 4.6 to 5.0 (Table 13). All three trainings were praised by family support specialists for their engaging, hands-on activities, interactive presentations, and time allowed to ask questions. Typical comments were that the sun safety presenter "made learning fun;" the information in the CPR/first aid session was "interesting and easy to understand;" and the creative writing seminar provided a "safe environment to share writing skills."

Table 13

Staff Training: Core Knowledge

Training Session	N	Training Was Useful*
CPR/First Aid	6	4.9
Sun Safety	8	4.6
Literacy Through Creative Writing	4	5.0

*Training was worthwhile; staff learned from training; will use what was learned.
Ratings: Scale ranges from 5 = Strongly Agree to 1 = Strongly Disagree

Staff survey data suggest that family support specialists are relatively comfortable with their overall level of core knowledge. On two items that assess this area ("I have sufficient knowledge to carry out the goals of the EHS program." and "Overall, my training has prepared me to do my job well."), all family support specialists either "strongly agreed" or "agreed," which represents an increase over the previous year's ratings. In a few areas of core knowledge, however, some family support specialists appeared to be less positive. For example, three of 11 family support specialists reported their knowledge as "barely adequate" regarding childhood diseases and risks associated with premature birth and low birth weight. Suspected problems in these areas can usually be referred to staff nurses. Four family support specialists also reported their knowledge was "barely adequate" regarding agency and community resources for children with special needs.

One training issue that cuts across all program goals also came to light during interviews and focus group discussions: the need for a standardized new employee orientation. Family support specialists suggested new staff immediately receive an EHS-specific orientation to quickly learn about core program values, setting boundaries, and procedures for working with the male involvement specialist.

Discussion

The bulk of training efforts during 1997-98 targeted knowledge and skill areas previously identified as high priorities. Foremost among these were child development and parent-child relationships. By the end of the program year, supervisors felt that family support specialists were paying more attention to child development and parent-child relationships during their home visits, alleviating a concern from last year.

Two new assessments of staff knowledge and skills, however, raised some questions about the effectiveness of the training with regard to conceptual knowledge and practical applications. An assessment of material covered in a child development seminar revealed a wide variation among individuals in their content knowledge. The assessment of parent-child interactions showed that family support specialists differed widely in their ability to identify salient features of parent-child interactions and to evaluate the quality of those interactions. The assessment suggested similar variation in their ability to evaluate the behavior of infants and toddlers. While results from these assessments may be less positive than hoped for, they can help program managers prioritize topics for the 1998-99 staff training schedule, and the results provide baseline data from which to measure future improvement.

One of the clear strengths of family support specialists in their work with families during the last two years has come in the arena of building supportive relationships. A distinct trend in parent survey responses illustrates this point: the longer

parents are in the program, the more positively they rate their relationships with family support specialists. One potential downside of strong provider-client relationships, however, is increased difficulty in maintaining professional boundaries. Issues of setting boundaries have already caused some difficulties and concerns for program personnel, and family support specialists have indicated they would like continuing discussion of the topic. They have also requested more training on the topics of adolescent development and strategies for working with adolescents.

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Community Outcomes

The philosophy of community building—one of four Early Head Start cornerstones considered essential to high-quality comprehensive programs—regards collaboration as integral to creating a community environment that supports young children and families. Revised Head Start Program Performance Standards underscore this philosophy, counseling increased collaboration between Early Head Start/ Head Start programs and other community service providers. The revised performance standards (*Federal Register*, November 5, 1996) direct grantees to "...take an active role in community planning to encourage strong communication, cooperation, and sharing of information among agencies and their community partners and to improve the delivery of community services to children and families." It goes on to say that grantees "...must take affirmative steps to establish ongoing collaborative relationships with community organizations to promote the access of children and families to community services that are responsive to their needs, and to ensure that Early Head Start and Head Start programs respond to community needs..." (Subpart C, 1304.41, (a)1, (a)2).

Program goals for Phoenix Early Head Start parallel the performance standards, with the following desired community outcomes: 1) to facilitate the development of parent/child support services (*e.g.*, child care, health, and education), and 2) to establish relationships with community service providers and provide coordinated services to program families. Achievement of these goals is pursued through linkages, collaboration, and leadership.

Progress towards desired community outcomes was explored in several ways. Quarterly program reports furnished information about linkages between EHS and other community programs. Data were also gathered through evaluator observations of selected staff meetings, with year-end interviews and focus groups providing additional information. Periodic meetings between the evaluator and program administrators also facilitated ongoing appraisal of broader-based collaborative efforts.

While EHS quarterly administrative reports document specific community activities, this section takes a broader look at community outcomes, examining not only progress towards developing accessible community networks that are sensitive to families' needs, but also collaborative leadership efforts aimed at improving the community environment for vulnerable children and their families.

To create a network that maximizes support for program families, EHS community building efforts follow several different paths. Linkages have been made connecting program participants with existing services, and activities are in progress to augment existing resources and fill service gaps. A third level, broader in scope, involves actions designed to assist in the development of more integrated, comprehensive, support service systems.

Establishing Linkages

Program efforts during the past year have continued to focus on establishing direct linkages with existing community resources that benefit EHS participants. Families have been connected with a source of health care through a linkage with the "Breaking the Cycle" program, which provides community-based health services for people without a regular source of care. Parents have also been participating in HIV/STD prevention classes designed for sexually active 16-19 year olds, through a program connection with the Youth Care organization. In addition to conveying important information to EHS teens, Youth Care makes a financial contribution to EHS

for each class attended by at least ten parents. The Village charter school for pregnant and parenting teens also continued to be a resource for EHS parents this year.

Ongoing linkages with agencies such as Planned Parenthood and the Arizona Family Planning Council also provide support to EHS parents. Although two joint family planning-related grants submitted last year were not ultimately funded, connections between these agencies and EHS remain intact. Phoenix Early Head Start has also continued to develop links with governmental units with whom program participants interact, such as the Department of Economic Security, Child Support Enforcement Division. These types of connections link parents with needed services, while at the same time fostering better understanding in those organizations of how to assist families.

Expanding Resources

When programs and agencies come together to support families, it often broadens insight about existing problems and helps generate new solutions. Collaborative problem-solving in these circumstances can result in maximizing the breadth of available resources, and ultimately increases the community's capacity to assist families.

This process of "joining forces" was notable during the past year in collaborative activities between EHS and the state's Developmental Disabilities Division (DDD) and Early Intervention Program (AZEIP). Program administrators and DDD managers moved from creating a flow chart that develops a pathway to link EHS special needs families with available state services, to forming a team to help coordinate services for special needs families. The team, composed of an EHS parent and personnel from both agencies, is part of a national Early Head Start training initiative to support families with children with disabilities. After attending the first in a series of planned national conferences, the team developed coordinated methods for providing services to EHS special needs families. Future plans include some joint local training for EHS and DDD staff. In addition, the two groups are planning to implement a support group next year for teen parents with children with disabilities—which would extend beyond EHS to any teen parent who could benefit from this type of support.

Phoenix Early Head Start has also been a catalyst in helping expand resources for young fathers through development of the Young Fathers Network, a community collaboration among more than 20 male involvement programs. In addition to identifying a network of support services for fathers, the initiative affords these young men expanded opportunities to interact with and support each other through joint programming. One result of these efforts is that EHS, on behalf of the Young Fathers Network and in collaboration with the City of Phoenix Human Services Department, received funding from the St. Luke's Charitable Trust for a "Healthy Communities Technical Assistance Partnership," to help identify existing local resources for young fathers and to identify and/or establish additional needed services.

A third relationship that has served to marshal community resources is the collaboration between SWHD and the Village charter school for pregnant and parenting teens. In addition to the linkage described earlier for EHS parents attending the school, collaborative efforts at the agency level helped sustain the Village's child care center over the past year. After difficulties with the school's child care provider threatened the continued viability of this key program component, SWHD administrators agreed to temporarily take over management of the center to help it get on track. With the assistance of SWHD personnel and financial resources, both organizations were committed to helping ensure that the teen parents who attend the school have available options for quality child care.

Developing Integrated and Comprehensive Services

Through a variety of avenues, EHS is working towards developing integrated, comprehensive service systems to support families and their very young children. Creating these types of support systems begins with identifying and expanding existing resources. Relationships that extend resources, such as partnering with DDD, the development of the Young Fathers Network, and

the collaboration with the Village, are important steps in that direction. Phoenix Early Head Start families also benefit from the resources available to them through the program's relationship with other SWHD agency initiatives, such as the SWHD Good Fit Center's leadership of an infant mental health consortium. These connections ultimately afford EHS families access to more comprehensive support services in this area.

Sustainable community support for families and young children is also pursued through broader local and statewide activities. Phoenix Early Head Start and Southwest Human Development administrators and managers continue to be engaged in efforts to focus attention and marshal support for children birth-to-three and their families. Through their participation in groups such as the Arizona State Head Start Association (ASHSA), EHS managers and staff remain committed to maximizing the integration of issues for children ages 0-3 into the early childhood policy arena. In addition, SWHD has undertaken a new task that holds considerable promise. In partnership with the Children's Action Alliance, a child advocacy organization, the agency has embarked on a two year initiative called "Smart Beginnings" that is aimed at advancing a statewide policy agenda for Arizona's youngest children. This project, which is funded through St. Luke's Charitable Trust, is a research, planning and system development effort to design a public/private model for supporting families and promoting the healthy development of children from conception through age three.

Technical Assistance

Technical assistance—while not traditionally viewed as a "community outcome"—nonetheless contributes to building community capacity. Phoenix Early Head Start managers have continued to provide assistance to groups, both locally and nationally, who are in the process of developing Early Head Start programs. Through this consultation and on-site visits with EHS staff and managers, new programs can gain knowledge about program design and "lessons learned" from the Phoenix Early Head Start experiences. This assistance helps smooth the start-up of new Early Head Start programs, and ultimately increases a community's capacity to assist children and their families.

Discussion

Phoenix Early Head Start appears to be making appreciable progress towards the goal of building community capacity to assist young families. At a basic level, available options and support for program families are continuing to be developed. As program components have evolved and gained stability over the past year, new linkages have been developed to connect participants with identified needs (*e.g.*, personal health care), while earlier linkages have also been maintained.

At the same time, some program linkages have evolved into more collaborative relationships that are serving to coordinate and expand available community resources. Connections with Step-Up and other young father programs have grown into a broader-based community coalition that is expanding resources and pursuing new funding sources to support its agenda. The participation of the Step-Up director on the SWHD Head Start Policy Council also lays the foundation for collaboration at the program/agency policy level—certainly a formative step in community-building. Similarly, the program relationship with the Village charter school has evolved into a bona fide SWHD agency collaboration, with a commitment of both fiscal and human resources.

The EHS relationship with DDD also illustrates the evolution of program connections over time. At a basic program level, EHS was charged with integrating children with disabilities into its service population. Initial linkages with DDD focused on how to connect those program families with state services. Taking advantage of national Early Head Start training opportunities, this initial linkage has developed into a joint EHS/DDD team to help coordinate services. Meanwhile, future plans to provide joint staff training and implement a support group for teen parents of children with disabilities—available to any family in this situation—moves still further along the continuum of community capacity building.

Perhaps most promising, EHS's parent agency, SWHD, has become involved in the design of a statewide system to support families and their very young children. This endeavor further

extends the agency's commitment to young families (which is underscored through EHS)—and is providing the leadership necessary to initiate sustainable, comprehensive support systems for this population.

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The Program Planning and Development Process

It often takes two or three years to get all planned program components up and running. And typically, somewhere along the way, circumstances will cause the program to veer somewhat from its original course. Continuous program improvement evaluation, however, provides an opportunity to assess program planning and development while it is unfolding. Therefore it can assist program stakeholders as they navigate their way through the process.

Over the course of the past year, information about program planning and development was gathered through evaluator observations and periodic discussions with EHS/SWHD administrators. Additional data were obtained through year-end interviews and focus groups. This section examines the SWHD/City of Phoenix partnership, as well as the internal EHS/SWHD collaborative process.

At the start of the 1997-98 program year the EHS technical team—the primary conduit through which the EHS/City of Phoenix partnership was originally operationalized—was at a critical juncture. The technical team had been characterized during its first two years by ambiguity and ambivalence. But while partnership activities were limited and attendance by City of Phoenix technical team members had declined considerably during 1996-97, most program stakeholders at year-end still expressed interest in trying to strengthen the partnership. Nevertheless, concrete plans to redefine the technical team and revisit the partnership during 1997-98 were not actualized. Though administrative level interactions between EHS/SWHD and the City of Phoenix Head Start Program did occur (primarily with respect to Early Head Start expansion discussions), other activity was minimal.

Relationships with other City of Phoenix entities, however, made considerable progress, and new associations emerged. Collaboration between EHS and the Step-Up Program for young fathers experienced ongoing success, and they continued to share some staff training opportunities and program activities. Increased collaboration between the programs this year was also evidenced by the participation of the Step-Up director as a community representative on the SWHD Head Start Parent Policy Council, and by the joint development of an all-day Father's Day event. As part of the male involvement component, EHS also established relationships within the city's Community Services division to expand the scope of male-related activities in the city's HUD (Housing and Urban Development) designated Enterprise Community and beyond. Working with the City of Phoenix, EHS was instrumental in obtaining a technical assistance grant to work with the Young Fathers Network, a collaboration of over 20 local male involvement programs. Program personnel are currently exploring the possibility of obtaining a funded position through the city's welfare-to-work initiative, which would further assist EHS families in becoming self-sufficient.

In describing their vision of the relationship between EHS and the City of Phoenix during the remaining two years of the program, EHS/SWHD managers and administrators agreed that, at the program level, the relationship with the city's Head Start program will likely focus on the transition of families from one program to the other. They also anticipate that these transition activities will occur by establishing direct connections with the individual Head Start delegate agency directors who will be receiving EHS families. Broader administrative "partnership" issues are expected to center on how to proceed with possible program expansion over the next few years and how to plan for 0-3 services after the current grant cycle ends.

Collaboration with programs within the larger SWHD agency structure is also an important part of program planning and development for Phoenix Early Head Start. The past year was characterized by increased internal collaboration in some areas, while other relationships remained unchanged. Program supervisors, managers, and administrators all commented on the successful and growing

relationship between EHS and the SWHD Early Intervention Department, with several people citing the leadership of the Early Intervention director in facilitating this process. The two EHS child development/disabilities specialists are also part of the Early Intervention staff, each dividing their time between the two programs. Plans are currently being explored to provide joint supervision for these staff members, which would further enhance the collaborative nature of the relationship. Another important step this year was the development of processes and procedures between the two programs for supporting EHS families with disabilities.

An increase in collaborative activities with the SWHD Training Department was also noted by several people interviewed. The training department director took a more active role in working with EHS this year, following the departure of the male involvement coordinator who had previously played that role. The increased engagement of the director was viewed by program administrators as precipitating additional linkages between the training department and EHS. This year, the SWHD staff member who leads the agency's six-week child development curriculum (attended by EHS staff) also provided two training sessions for EHS families, one on literacy and one on child development. She was also part of a brainstorming session with the EHS evaluation subgroup to help develop an evaluation instrument assessing the effectiveness of staff training. In another collaborative activity, the training department director "debriefed" with EHS staff following a controversial parent training session.

Other internal collaborative efforts this year were either unchanged or reportedly less focused than those just described. Joint meetings between EHS and the SWHD Healthy Families management staff have continued over the past year. With few exceptions, however, these meetings were not viewed as helpful by most EHS personnel, but instead were described by some as "uncomfortable for everyone," in part because EHS has many more resources—and therefore can do much more—than Healthy Families. There was agreement as well that the relationship between EHS and the SWHD Basic Head Start program did not change over the course of the year. With the exception of the Head Start Policy Council, the two programs continue to be described as separate and isolated. Participation by EHS parents at the policy council level, however, remained notable. The sensitivity and responsiveness of the SWHD Head Start director and policy council leaders to the EHS parent representatives was again noted by all those interviewed. These sentiments were underscored by EHS parents, who are very positive about their experiences on the council.

Discussion

The partnership between EHS and the City of Phoenix has been characterized by somewhat of a shift in direction this year. The relationship with the City of Phoenix Head Start program, while continuing, has been more administrative than programmatic. At the same time, however, programmatic connections and activities with other city initiatives are moving in a more collaborative direction.

The lack of "ownership" and inactivity that described the relationship between City of Phoenix Head Start and EHS at the end of last year has not substantively changed, despite an articulated desire by program stakeholders to revisit the partnership process. One reason for this might be the marked increase in available funding since the inception of the original 68 Early Head Start pilot projects (including Phoenix Early Head Start). This movement towards funding numerous programs nationwide expands the possibilities and options for the development of new programs within the City of Phoenix as well. Along with the reality of their other program responsibilities (for which—unlike EHS—the city has fiscal connections) competing for attention, this might account for some lack of impetus by city stakeholders to regenerate partnership activities.

Ambiguity about the future, along with the attention required by ongoing program needs, might also have caused technical team issues to be a relatively low priority for EHS/SWHD. Given these circumstances, the most appropriate—and realistic—relationship at this juncture might in fact be to focus on the specific task of transitioning families from EHS to the applicable City of Phoenix Head Start programs.

Growth in other collaborative endeavors with the city, particularly among the EHS male involvement activities, the City of Phoenix, and other young father programs, are due in part to "timing and circumstance." These programs are at relatively early stages of figuring out how to maximize and integrate services for young fathers. Factors such as available funding to develop partnership programs, and the role the city can play in providing coordination and support for this process, increase the momentum for expanding these types of collaborations.

The program development process with respect to EHS/SWHD has also broadened as EHS continued to evolve over the course of the year. In the process of planning for their special needs families, EHS's relationship with the Early Intervention Department appears to be integrating well and heading in the direction of more collaboration. Similarly, expanded involvement between the Training Department and EHS also seems to have taken on some dimensions of collaborative planning. With respect to EHS and SWHD Basic Head Start, however, the relationship remains unchanged—with the notable exception of EHS parents' highly positive experiences with the Head Start Policy Council.

In summary, collaboration is taking place between EHS and SWHD activities/programs that directly affect EHS families and staff on a regular basis—servicing special needs families, staff training and development, and parent leadership development. The difficulties in integrating EHS and SWHD Basic Head Start are being encountered at a more conceptual level which, although limiting, will probably not change until or unless there is a programmatic "reason" to do so. Perhaps, as with the city's Head Start program, these connections will ultimately occur around family transition issues.

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Summary and Analysis

As of the end of the 1997-98 project year—Year Three of the five-year demonstration project and the second full year of program implementation—Phoenix Early Head Start can best be characterized as a fully evolved program that is on the right track. Planned program activities have been implemented, with some components expanding and others moving in new directions; and evaluation activities have generated both qualitative and quantitative data to assist program managers in continuous program improvement. The subsections that follow discuss progress and outcomes for children, families, and staff during the 1997-98 program year, and they review the processes involved in program evolution, building collaborative relationships, and building community capacity to serve young families.

Children and Families

The fundamental strategy of EHS is to provide support for low-income children and families through a combination of services that not only address the needs of the child, but also address the needs of the child's parents—thus enabling the parents to become better caregivers. The primary service delivery system for this strategy is a schedule of frequent home visits. Child and family issues currently predominate during these visits. Play groups and socialization activities also provide help for parents in understanding and building healthy relationships with their children.

Most indicators of child and family development support the conclusion that EHS program strategies have had a positive effect. While the gains on some of these indicators are small, when viewed in the aggregate they present promising trends in the domains considered essential for creating favorable outcomes for families. Among the trends: parent knowledge of raising a baby has increased; most children appear to be living in nurturing home environments; parents report more interactions with their children; parent mental health remains stable; many parents have attended school or job training programs and some have transitioned into full-time jobs; most parents have maintained appropriate health care practices for their children and themselves and many are practicing family planning; and parents of children with developmental concerns have followed through on referrals.

Not every indicator is positive, however. While parents have more knowledge of raising a baby, they seem unable to generalize this knowledge to expectations for their emerging toddlers. And while parents report more interactions with their children, some evidence suggests that the tone of these interactions may be more negative than previously—a finding that coincides with more infants transitioning into toddler stage. As more EHS children move into the limits-testing stages of toddlerhood, it will be important for staff to continue acting proactively in using home visits and other activities to focus parents on the developmental transitions their children are experiencing. Particular emphasis should be placed on age-appropriate expectations and parenting strategies for supporting and managing these transitions.

Progress towards this goal, however, as well as progress towards achieving any program outcomes for EHS children, will always be complicated by the fact that parents in the EHS target population are teenagers. As these adolescent parents begin to face off with their non-complying toddlers—each group engaged in their own personal struggles for autonomy—a "clash of wills" could occur. To help defuse this potential conflict and assist parents in building healthy relationships with their children, EHS staff will have to rely on a sound understanding of adolescent development and an effective arsenal of strategies for working with adolescent parents.

The program already seems to be having a positive effect in this area. Despite some apparent problems with their children's shift from infancy to toddlerhood, parents have not experienced a decline in overall mental health, as might have been expected. To the contrary, indicators of their parenting stress, coping skills, and sense of control have remained relatively stable and positive over time. One possible explanation for this stability is that the EHS program has been functioning as a "protective factor" for parents by giving them an outlet when they face emerging problems with their children. Some evidence for this conclusion comes from participating parents, who frequently noted that EHS not only helps them to become good parents, but also puts them in contact with other teen parents in similar situations. Family support specialists also indicate that exposure to peers, empowering experiences through parent committees, and positive interactions with their children has helped to increase parents' sense of independence, self-esteem, and pride. Participation in these activities would seem even more likely to be important for those teens who experience feelings of isolation and lack of social support—and more than one third of EHS parents expressed these feelings when they entered the program.

Staff Development

Phoenix Early Head Start is a child development program operating within the larger context of family support and development. In order for family support specialists to carry out program goals, they must possess strong skills in both domains. The majority of staff training sessions during 1997-98 addressed topics in these two areas. But while family support specialists paid more attention to these areas during home visits this year as compared to last year, staff assessments showed wide variation among individual family support specialists in their knowledge and skills.

Following up on concerns about staff training raised by these assessment results, EHS/SWHD managers have made a decision to intensify training on child development and parent-child relationships during the upcoming year, and also to implement a child development curriculum that will assist family support specialists as they work with families. These steps should fill in some skill and knowledge gaps among family support specialists and better equip them to help children and families. A structured approach that includes more focused and cohesive child development training, consistent reinforcement of newly-learned concepts and skills during supervision, and more opportunities to work with the child development/ disabilities specialists, should contribute substantially to the staff's professional development.

There is continued evidence that family support specialists are effective in working with teen parents; however, this success has a potential downside. By building strong relationships with parents, family support specialists can encounter difficult boundary issues. The topic of setting boundaries was addressed during staff training in 1997-98 as well as in the past, but experience suggests that this topic will require ongoing discussion and clarification throughout the life of the program—both for staff and for supervisors and managers.

The multi-faceted training goals and desired outcomes for EHS staff require a training plan that is systematic and deliberate in its formulation. But it must also be responsive to emerging needs. Wisely, program administrators had already committed resources to child development training at the time of this report. It will be important next year to assess whether this training makes a difference for program participants, and to continue to make well thought out adjustments to the staff training plan as needed.

Building Community Capacity to Support Children and Families

As part of their mission, Early Head Start/Head Start grantees have been directed to "... take affirmative steps... to *promote the access of children and families to community services*...responsive to their needs and...ensure that... *Early Head Start programs respond to community needs*..."(*Federal Register*, November 5, 1996). In order to meet this mandate, Phoenix Early Head Start is helping focus community attention, planning, and resources on children age 0-3 and their teen parents.

The program is attempting to accomplish this task by establishing linkages to, developing collaborations with, and providing leadership for community efforts. As with the evolutionary stages of the EHS program itself, a few early elements of the community-focused endeavors have experienced changes over the last two years. Some activities that began as basic program linkages have now become bona fide community capacity-building efforts, while others that were initially envisioned as full collaborations are currently functioning on a more narrowly defined basis.

Now that EHS has moved beyond its "start-up" phase and overcome many of the difficulties inherent with inception, the program has begun enlarging its scope to include community-building. Two goals have been of particular focus during the past year: expanding support for young fathers, and coordinating services for young parents with special needs children. An early expectation of program planners has also begun to show promise—the program's location within the HUD-designated City of Phoenix Enterprise Community (EC) has created opportunities for viable collaborations. For example, an EHS collaboration with the city and other community programs involved in the Young Fathers Network has helped expand available resources for teen parents, both in the EC and beyond. In linking program participants with various services, EHS has also made contact with a job linkages program in the EC designed to connect local residents with local jobs. While this linkage has not been well used by EHS participants as yet, it illustrates how program efforts over the last year have broadened relationships within the EC. And, as more EHS participants begin to seek work, this type of connection will become increasingly valuable.

But as relationships with some city programs and activities have expanded in new directions over the past year, an existing partnership with City of Phoenix Head Start has moved in a different direction. This partnership has shifted from "big picture" program advisement and collaboration between the two, to discussion of specific administrative-level issues and policies. This shift arose, in part, from changes in federal regulations that have implications for future funding and administration of Early Head Start programs, as well as pragmatic issues such as time constraints and the perceived "costs and benefits" of collaborative activities. In the next few years, joint planning will likely occur around issues such as funding strategies for Early Head Start programs at the conclusion of the current grant, and discussions between SWHD and the City of Phoenix Head Start to determine how best to serve Phoenix's 0-3 population.

Other alliances have also begun to expand community capacity for serving children 0-3 and their families. In collaborating with DDD and the Village charter school for teen parents, EHS has taken steps to not only increase options for program participants, but also to expand access to resources for teen families in the larger community. Ongoing program linkages have produced broader community impacts as well. Program managers and staff indicate that continuing connections between the male program component of EHS and the Child Support Enforcement division of DES have changed the way that agency "thinks" about child support enforcement and "deadbeat dads."

The holistic approach essential for building community support for young families has also been fostered through the synergistic relationship that exists between EHS and SWHD agency initiatives. EHS has benefitted from SWHD's active involvement in many projects and collaborations—such as the earlier-mentioned infant mental health services available through the Good Fit Center. EHS has also benefitted from its parent agency's investment in quality child care. When the Village charter school, which several EHS parents attended, experienced difficulty with its existing child care arrangements, SWHD was able to provide resources to help remedy the immediate situation. And additional child care assistance—vital to EHS participants and other teen parents—will be forthcoming through the development of a new SWHD child care initiative currently underway. In return, Phoenix Early Head Start has provided SWHD entree as a key player in the statewide "0-3" public policy arena.

In summary, EHS continues to be involved at all levels with helping to build community capacity

for the support of young children and families. While some collaborative efforts have grown in the past year and new avenues for action were explored, others shifted direction and became less "active" than originally anticipated. These changes can be understood as part of a natural evolutionary course for collaborative community ventures. An essential characteristic for the success of programs like EHS that are involved in community building efforts will be the ability to capitalize on emerging opportunities and adjust to unanticipated circumstances that invariably occur.

Program Successes and Remaining Challenges

As a program moves through its "life cycle," the challenges it must face undergo a gradual shift—from initial implementation details, to mid-course adjustments, to later concerns involving transition issues. Its strengths may also shift through the life cycle—from an early reliance on its conceptual underpinnings, to later analysis of how well its components have actually evolved. Such shifts appeared to be in progress as EHS personnel discussed the program's successes and remaining challenges at the end of the 1997-98 year. Their comments and analyses addressed issues deeper in the program cycle, reflecting the maturing process underway for Phoenix Early Head Start.

An important success identified by program managers and administrators was the evolution and expansion of the EHS male program component, specifically in terms of the role it has played in community leadership and development of young father initiatives. Another program success involved the launch of all planned child development activities. Also, the child development/disabilities specialists were again specifically identified by all interviewees as a "program success," underscoring the strong desire among staff for accessible consultation and assistance in this area.

Other, more general successes, include EHS's progress in working with (and understanding the needs of) teen parents, and the fostering of healthier parent-child interactions. These also remain ongoing challenges as staff continue to face both the complexities of meeting the needs of adolescent parents, and the difficulties of implementing child development knowledge/concepts with families. A training seminar on adolescence this year gave family support specialists more skills in this area; continued training should further assist them in their work with parents. Plans for an intensive focus on child development during staff training in the upcoming year, and increased consultation and support from the child development/disabilities specialists should also do much to meet remaining challenges in child development.

The program also faces two significant challenges related to long-term support of program families: one is interpersonal, the other programmatic. First, the prospect of ongoing "boundary issues" was identified as a challenge by both EHS managers and staff. Boundary problems are expected to crop up over time as family support specialists become more deeply involved with their families, potentially blurring the limits of professional relationships. The overwhelming consensus was that more staff training and support were needed in this area. The second challenge relates to families who transition out of the program. This transition has already gotten underway with the exit of some "successful" participants (who left because they no longer need EHS services), and it will increase as children in the program reach their third birthday, making them no longer eligible for EHS. The primary concern centers on the need to find quality programs for these youngsters because there may not be enough Head Start classrooms available to take three-year-olds. Another challenge raised by program personnel goes back to the issue of boundaries, and a concern that families may want to maintain relationships with program staff after their exit. These challenges surrounding transition already present a concern for some EHS personnel, but the degree to which they will become problematic is not fully known at this time.

An ongoing program challenge since inception has been staff recruitment and retention. The 1997-98 program was no exception, with several staff departures through both self-selection and termination. Reflecting the program's maturity

was a newly articulated need to take steps to prevent staff "burnout." Resolving these problems is crucial to efficient service delivery because, as has been demonstrated in the past, the timely recruitment of qualified new staff members can be a difficult task.

A final set of program challenges is more broadly focused. The first is to make EHS more visible in the community. Linkages and collaborations described earlier in this report notwithstanding, program managers and administrators articulated the need for EHS to develop a more visible community presence among both service providers and policy makers. Since all program components are in place and operating effectively for the most part, now would be the appropriate time to acquaint the larger community with both the benefits and implications of Phoenix Early Head Start. The second challenge regards funding. As the current grant cycle moves into its final two years, program managers feel the need to seek out diversified funding sources to assist Phoenix Early Head Start in the future. Broadening the base of local support for EHS would greatly strengthen its future viability.

A State and Local Policy Perspective

It is evident that children 0-3 and their families have made it to the "radar screen" of Arizona decision makers. Initiatives are currently underway to increase state subsidies for child care, increase funding for a successful child abuse prevention program (Healthy Families), and reestablish funding for prenatal outreach services (Health Start). Prevention and early intervention, specifically with regard to prenatal and early childhood services, is also an integral component of a recent community-wide violence prevention initiative (Waits, Johnson, *et al., 1998).*

Phoenix Early Head Start administrators can contribute much toward helping policy makers understand the societal benefits that accrue when they support programs for young families. Information and knowledge gained from the program can also help inform the public debate. Some of the state-level activities undertaken by EHS administrators and managers were discussed earlier in this report. Now that Phoenix Early Head Start has provided SWHD entree into the 0-3 policy arena, the agency's leadership has become evident in such strategic planning activities as the Smart Beginnings initiative that has been undertaken in collaboration with the Children's Action Alliance. This work holds promise for putting into place actions that will have positive, long-term effects for Arizona's youngest children and their families.

As a program for teen families, Phoenix Early Head Start is also in a position to inform public policy issues surrounding welfare reform. Recent welfare reform initiatives such as mandates for school and work, and the reduced or restructured benefits for cash assistance, food stamps, and assistance to immigrants, when combined with the growing need for services such as child care and reliable transportation, substantially add to the difficulties that already face teen parents. Analysis of the needs and experiences of EHS's teen population will generate important questions about the types of services necessary to help these families succeed, and about the service "system" itself. Knowledge gained through the EHS male program component, in particular, can help decision-makers understand what it will take to move young fathers towards accepting financial and emotional responsibility for their children, and towards economic self-sufficiency.

Creating sustainable, systemic changes for vulnerable young children and families requires a political climate that champions a broad spectrum of family support programs. With its focus on both early childhood development and teen parents, Phoenix Early Head Start is in a unique position to understand "what works" for these young families. But it would be short-sighted for program managers to focus their attention too narrowly. Rather, the knowledge gained from programs such as EHS should be integrated into a larger community perspective. Ongoing efforts must continue to help decision-makers see the critical connections between strong early childhood and family support systems and current public policy concerns regarding welfare reform, employment, education, and violence prevention.

Recommendations

The following recommendations are offered based on evaluation data gathered during the 1997-98 program year. Because Phoenix Early Head Start is first and foremost a child development program, the first two recommendations address specific issues in this domain. The remaining two recommendations address broader process and policy areas.

- ***Implement a focused, cohesive training agenda to provide EHS staff with sustained, comprehensive opportunities to improve their child development skills and knowledge.***

  If EHS is ultimately to improve outcomes for children, it is critical that staff have sustained and ample support to increase their professional skills in this domain. EHS administrators should maintain their commitment to staff development, by employing a structured approach for providing program staff with ongoing, intensive training and supervision in child development.

- ***Deal proactively with issues involving children's transition from infant to toddler.***

  It is becoming clear that many EHS parents have inappropriate developmental expectations for their children once they become toddlers. As a result, they may use undesirable strategies (*e.g.*, physical punishment) to deal with what is, in fact, normal toddler behavior. Such "red flags" should serve as signals for staff to adopt a more proactive approach with parents as they experience this important transition of their children from infants to toddlers.

- ***Institute a standardized "EHS new employee orientation" to clarify program values, goals, guidelines, and procedures.***

  New EHS staff members need a vehicle to help them quickly grasp both the guiding principles and everyday procedures needed to do their job. An overview of program "do's and don'ts," as well as written information about core program values, and guidance on how to access and use all EHS program components would greatly help. Given the complexity and multi-faceted nature of EHS, and the ongoing recruitment of new staff, it would be prudent to develop a program-specific orientation for new employees.

- ***Develop and implement a strategy to increase awareness of EHS among service providers and policy makers.***

  The more that service providers become familiar with EHS, the greater the likelihood that EHS can identify potential participants and better serve current ones. Similarly, the more cognizant policy makers are of EHS, its benefits, and outcomes, the greater the likelihood that EHS can help inform policy decisions. In order to benefit current program participants and contribute to a community legacy of coordinated, collaborative family support systems, EHS administrators should develop a plan to broaden awareness of the program and its assets.

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Appendix A

Phoenix Early Head Start Continuous Improvement Evaluation Plan

Desired Outcomes	Evaluation Questions	Data Sources/Measures
A. Family		
A1. Adult - Child Relationships Parents and other primary caregivers will develop positive adult-child relationships with the child, including: a. positive mother-child interaction b. positive father-child interaction c. effective parenting skills d. reduction of negative parenting behaviors	To what extent do EHS parents show evidence of positive adult-child relationships (including parenting skills)?	Raising a Baby/Raising a Child Parent-Child Activities Home Assessments Discipline Parent-Child Observations checklist
A2. Parent Mental Health Parents will exhibit indicators of positive mental health, including: a. using appropriate decision-making skills b. using effective coping skills in stressful situations c. not engaging in addictive behaviors (e.g., drug abuse, alcohol abuse, chronic gambling, eating disorders) d. demonstrating evidence of positive social interaction appropriate for their age	To what extent do EHS parents exhibit indicators of positive mental health?	Parenting Stress Index General Life Events Scale Coping Strategies Checklist Self-Efficacy Scale Self-Esteem Scale Program data
A3. Personal Health Care Practices Parents will exhibit recommended personal health care practices, including: a. obtaining appropriate prenatal, delivery, and postnatal care b. preventing unplanned pregnancies c. seeking appropriate medical care for routine and chronic health problems d. using preventive health care services	To what extent do EHS parents follow recommended personal health care practices?	Program data Case studies
A4. Educational Self-Sufficiency Parents will demonstrate progress in high school *or* higher education *or* job training programs appropriate to their individual goals.	Do EHS parents participate in high school, higher education, or job training programs appropriate to their goals?	Program data Case studies

Desired Outcomes	Evaluation Questions	Data Sources/Measures
A5. Economic Self-Sufficiency Parents will make progress along a continuum toward economic self-sufficiency as evidenced by: a. progress toward outcome A4. b. employment status and earned income c. reduction in dependence upon subsidies and/or community emergency resources d. access to dependable and reliable transportation e. access to and use of quality infant-toddler child care for their child f. adequate housing g. using effective household management and budgeting skills h. literacy	Do EHS parents show evidence of progress along a continuum toward economic self-sufficiency ?	Program data Case studies
B. Infant-Toddler		
B1. Infant-Toddler Development Infants and toddlers (who do not have developmental delays or disabilities) will demonstrate age-appropriate development in all developmental areas including: a. cognitive development b. language and speech development c. social-emotional development d. physical (fine and gross motor) development	To what extent do infants and toddlers in the EHS program demonstrate positive developmental indicators (cognitive, language, social-emotional, physical)?	IDA Denver
B2. Developmental Delays or Disabilities Infants and toddlers who are identified with potential developmental delays or disabilities will be referred to and receive appropriate intervention services and will show progress in all developmental areas within the capacity of their ability.	Do infants and toddlers in the EHS program who are identified to have developmental delays or disabilities receive appropriate intervention services and show developmental progress?	Program data IDA Denver
B3. Healthy Parent-Child Relationship Infants and toddlers will show evidence of a healthy (i.e., developmentally appropriate) parent-child relationship including: a. responsiveness to parent(s) b. positive interactions with parents	To what extent do infants and toddlers in EHS show evidence of a healthy parent-child relationship?	IDA Parent-Child Activities Home Assessments Parent-Child Observations checklist

Desired Outcomes	Evaluation Questions	Data Sources/Measures
B4. Infant-Toddler Health Infants and toddlers will be healthy, as evidenced by: a. evidence of thriving (i.e., no non-organic failure to thrive) b. receive immunizations according to CDC periodicity schedule c. receive well-baby and well-child check-ups according to CDC periodicity schedule d. receive appropriate medical treatment for routine and chronic health problems e. receive additional developmental evaluations and related services if recommended f. live in a safe home environment that is free from hazards	Are infants and toddlers in the EHS program physically healthy?	Program data National Health Study: Safety
C. Staff		
C1. Supportive Alliances with Families Staff will acquire knowledge and demonstrate skills in establishing supportive and effective alliances with EHS families as evidenced by: a. non-threatening, sensitive, and ethical interactions b. empathic, genuine, and collaborative relationships c. sensitivity to families' culturally related values/issues	Did staff learn about and develop supportive alliances with EHS families?	Staff surveys Supervisor survey Videotape analysis Parent survey Focus groups
C2. Strategies for Adolescent Parents Staff will utilize appropriate strategies for working with adolescent parents and at-risk families that reflect an understanding of the importance of: a. developmentally appropriate goals and program activities b. a family systems perspective c. self-determination d. self-sufficiency e. risk and protective factors	Do staff understand and use intervention strategies appropriate for EHS parents?	Staff surveys Supervisor survey Videotape analysis Parent survey Focus groups
C3. Child Development and Parent-Child Relationships Staff will acquire knowledge and demonstrate skills in working with families on early child development and parent-child relationships including: a. infant-toddler development b. attachment c. positive parent-child interaction d. the role of young fathers	Do staff understand and help EHS parents develop positive adult-child relationships (including parenting skills and parent-child interactions)?	Staff surveys Supervisor survey Videotape analysis Parent survey

Desired Outcomes	Evaluation Questions	Data Sources/Measures
C4. "Core" Knowledge Staff will acquire "core" knowledge essential for implementing the Phoenix Early Head Start program including: a. adolescent development b. adolescent health/mental health c. perinatal care d. family planning e. well-child care f. community-based resources g. child care	Did staff acquire the core knowledge necessary to implement EHS program services?	Staff surveys
D. Community		
D1. Phoenix Early Head Start will facilitate the development of parent/child support services including: a. child care b. health services c. education	To what extent were support services established?	Program documentation
D2. Phoenix Early Head Start will establish cooperative relationships with community service providers and provide coordinated services to program participants.	To what extent were cooperative efforts with community service providers implemented?	Documentation of the collaborative process Survey, interview, and observation data
E. Policy		
E1. State and local policy makers will become aware of the benefits of Early Head Start and support policies that address the needs of pregnant and parenting teens and their young children.	Are state and local policy makers knowledgeable about the benefits of the Early Head Start program? To what extent does knowledge gained from the Early Head Start program influence policy makers in their decision-making related to teen parents and their young children?	Documentation of efforts to communicate Early Head Start program results to state and local policy makers (e.g., meetings, briefings) Survey of selected state and local policy makers

Appendix B

Summary of Data Collection Instruments And Methodological Notes

Findings were reported only for those correlations that were statistically significant at probability < .05.

Data analyses do not include special needs families—with three exceptions. Special needs families *are* included in the Public Assistance Snapshot, the Profile of Families with Inadequate Resources, and the General Life Events data.

Data analyses are based on all participants for whom data were available regardless of whether or not some of these participants subsequently disenrolled from the program.

The participant assessment instruments described below are included in the Phoenix Early Head Start Enrollment Assessment and the six month, 12 month, and 18 month Assessments.

Raising a Baby/Raising a Child, Safety, Parent-Child Activities, Parenting Stress Index and the Home Assessmentwere adapted from the national *EHS 14 Month Parent Interview* and *Interview for Parents of Two Year Old Children*.

Self-esteem was measured with an adapted form of Rosenberg's 10-item *Self-Esteem Scale* (1965). Participants are asked whether they strongly agree, agree, disagree or strongly disagree with a variety of both positive and negative statements. Item responses combine to yield a seven-point scale. Scores range from 0 to 6, with low scores indicating high self-esteem and high scores indicating poor self-esteem.

Self-Efficacy Scale is based on Pearlin's *Mastery Model* (1981) and measures the extent to which an individual views their life circumstances as within their own control. The scale is comprised of seven statements, with which participants indicate whether they strongly agree, agree, disagree, or strongly disagree. The self-efficacy score is calculated by taking the average of the item responses, with reversed weights for positive statements. Scores range from 1 (low self-efficacy) to 4 (high self-efficacy).

General Life Events is a shortened version of the *General Life Events Schedule for Children* (Sandler, Reynolds, & Ramirez, 1986). On this measure participants are asked to indicate which of the 20 stressful life events presented have occurred in their lives in the past month. The score is equal to the total number of "yes" responses given.

Coping Strategies is a measure composed of 24 items taken from the *Children's Coping Strategies Checklist* (Preventive Intervention Research Center, Arizona State University, 1992). These items represent different types of positive strategies that young people can use to deal with stressful life situations. For each statement, participants are asked to choose among four responses to best describe how often they have used each strategy to deal with their problems in the past month (never, sometimes, often, and most of the time). The average of all responses is calculated to find the score. Scores range from 1 (infrequent use of positive coping strategies) to 4 (very frequent use of positive coping strategies).

Raising a Baby/Raising a Child are, respectively, nine-item and 13-item scales adapted from the Knowledge of Infant Development Inventory (McPhee, 1981). Items assess participants' knowledge of infant/toddler norms and milestones, developmental processes, and caregiving strategies. The total score on these scales is comprised of the total number of correct responses.

Parenting Stress Index (PSI) is an abbreviated version of an instrument developed by Abidin (1995) which presents 13 statements that reflect parental distress and dysfunctional parent-child interaction. Parents are asked how much they agree with each statement (strongly agree, agree, disagree, strongly disagree). Scores on the PSI are calculated by reversing the weights for all items and calculating their average. Possible scores range from 1 (low parenting stress) to 5 (high parenting stress).

Safety is evaluated by assessing parents' knowledge of safety precautions. Participants are asked a number of questions from the *Early Head Start 14 Month Parent Interview*. Questions address the use of smoke alarms, car seats, and covers for electrical outlets, as well as participants' knowledge of what to do if their child swallows something poisonous.

Home Assessment: These questions were adapted from the Infant/Toddler form of the Home Inventory. For the purposes of this evaluation, a summary score is calculated for ten items designed to assess parents' contacts and interactions with their child. Three items are based on parent responses and seven items are based on interviewer observations. Interviewers code their observations after completing the visit.

Infant/Toddler Home Inventory assesses the quality of stimulation found in the early home environment. The instrument contains 45 items composing six aspects of home environment: emotional and verbal responsivity of mother; avoidance of restriction and punishment; organization of physical and temporal environment; provision of appropriate play materials; maternal involvement with child; and opportunities for variety in daily stimulation. An item receives a plus (+) if the behavior is observed during the home visit or if the parent reports that the condition or event described is characteristic of the home environment, with a total possible score of 45.

Parent-Child Activities is a tool designed to provide information about the types and frequencies of parent-child activities. Items draw upon parents' encouragement of language development, routine activities, and experiences outside the house. Parents are presented with age-appropriate parent-child activities and asked how often they engaged in each activity with their children (ranging from "more than once a day" to "a few times a month" to "not at all"). Five items focus on activities between the primary caregiver and the child. If the child's other biological parent is also involved in the child's life, the primary caregiver responds to five additional items about the child's activities with that parent.

Parent-Child Observations Checklist is a locally developed instrument designed to elicit the family support specialist's perceptions of the quality of parent-child interactions, based on their observations over a six-month period. Family support specialists are asked their level of agreement (from "strongly agree" to "strongly disagree") with ten items describing specific aspects of parent-child relationships. The average of all responses is calculated to produce a score. Possible scores range from 1 (lower quality interactions) to 5 (higher quality interactions). In addition, family support specialists are asked to rate the overall parent-child relationship and to characterize its overall emotional tone.

Infant-Toddler Developmental Assessment (IDA), Provence Birth-to-Three Developmental Profile, uses observation by professional practitioners and parental report to assess the child's development in eight domains. For the purposes of this evaluation, a "developmental risk score" was created by summing across the domains of: gross motor, fine motor, relationships to inanimate objects, language/communication, self-help, and social/emotional (a composite of relationships to persons, emotions and feeling states, and coping behavior). Only scores for competent functioning were included; therefore, a higher score indicates higher functioning.

Denver II is a 1990 revision of the Denver Developmental Screening Test. The Denver is widely used to detect potential developmental problems in infants and young children by comparing the child's

performance on a variety of taskes to performance norms. The tasks are arranged in four sections: Personal-Social, Fine Motor Adaptive, Language, and Gross Motor.

Parent Survey is administered annually and is designed to elicit information directly related to EHS program services. Respondents are asked their level of agreement (from "strongly agree" to "strongly disagree") with 18 statements about different aspects of their relationship with their family support specialist. The survey also includes two open-ended questions about the program in general.

Staff Video-clip Analysis is a locally developed instrument designed to assess the extent to which family support specialists can implement what they learn with families. They view two video-clips: a mother with her 9-month-old child, and a mother with her 18-month old child. For two domains—child development and parent-child relationships—the family support specialist identifies critical strengths and critical concerns. Responses are compared to an answer key developed by an ad hoc EHS evaluation group. Two scores are calculated for each video-clip: 1) exemplar score—the number of correctly identified examples of a concept, 2) conceptual score—the number of correctly identified concepts underlying an exemplar.

Staff Knowledge Assessment is a local instrument that asks questions about concepts presented during staff training sessions throughout the year. Questions are provided by presenters of selected training sessions -- this year, specifically, SWHD child development curriculum, nonviolent parenting, discipline, boundaries, and demystifying adolescence. Questions are true-false, multiple-choice, "matching," and short answer.

Staff Surveys provide information about staff's self-assessment of their knowledge and training. Family support specialists are asked to rate (extensive, moderate, barely adequate, inadequate) their knowledge of and/or training on 40 topics. They are also asked their level of agreement (from "strongly agree" to "strongly disagree") with 13 statements related to EHS program "values" and practices.

Focus Groups are small discussion groups designed to obtain information about the perspectives of project participants and stakeholders regarding the EHS program. An interview protocol consisting of 6 to 10 open-ended questions is developed for each group. Participants are encouraged to engage in an exchange of ideas and explore various aspects of the project in depth.

Appendix C

General Life Events—After 12 Months in Program

Event	Percent
One of your brothers/sisters was very angry or upset	61.2%
Your parent(s) acted very worried, upset or sad (not because of anything you did)	54.4%
Your mom/dad talked about having serious money troubles	53.7%
A close family member or someone you live with committed a crime, got in trouble with the law, or was sent to jail	35.3%
Your relatives said bad things about your parent(s)	31.3%
People in your family physically hit each other or hurt each other (parents, brothers/sisters)	29.9%
Your close friend had serious troubles, problems, illness or injury	28.4%
Your brother/sister had serious trouble (with the law, school, drugs, etc.)	27.3%
Your mom/dad fought or argued with your relatives (aunts, uncles, grandparents)	25.0%
You saw your mom/dad drunk	25.0%
A close family member died	20.6%
Your mom/dad forgot to do important things for you that they promised they would do (such as take you on a trip, take you to nice places or come to your school or athletic event)	20.6%
A close friend of yours moved away	19.1%
A close friend died	17.6%
People in your neighborhood said bad things about your parent(s)	16.7%
Your parent(s) acted badly in front of your friends (yelled at them, criticized them, or was drunk in front of them	13.2%
One of your parents lost their job	11.8%
Your brother or sister suffered from a serious illness or injury (requiring bed rest for one week or more, hospitalization, any surgery or being in extreme pain)	10.4%
Your mom/dad suffered from serious illness or injury (requiring hospitalization or at least one week in bed)	8.8%
You suffered from a serious physical illness or injury (requiring bed rest for one week or more, hospitalization, any surgery or being in extreme pain)	8.8%

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